

18

BUDGET IMPACT OF PRESIDENT CLINTON'S HEALTH CARE PROPOSAL

Y 4. B 85/3:103-13

Budget Impact of President Clinton'...

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, NOVEMBER 3, 1993

Serial No. 103-13

Printed for the use of the Committee on the Budget



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BUDGET IMPACT OF PRESIDENT CLINTON'S HEALTH CARE PROPOSAL

WEDNESDAY, NOVEMBER 3, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to call, at 9:45 a.m., Room 210, Cannon House Office Building, Hon. Martin Olav Sabo, Chairman, presiding.

Members present: Representatives Sabo, Stenholm, Cooper, Slaughter, Price, Johnston, Blackwell, Pomeroy, Browder, Woolsey, Kasich, McMillan, Shays, Snowe, Herger, Smith of Texas, Cox, Al-
lard, Hobson, Miller, Smith of Michigan, and Hoke.

Also present: Representatives Clayton, Johnson of Texas, Kreidler, Meek, and Watt.

Chairman SABO. The committee will come to order. This hearing is on the question of health care reform and the President's proposal.

Let me make just a few opening comments and indicate to our witnesses that I commend you for the proposal that you have brought to the Congress. I think it is by far the most comprehensive proposal for fundamental change in this country and one of the most important ingredients that we deal with in our daily lives and in our economic lives in terms of reforming health care that we have ever seen. It is a proposal of historic proportions. It proudly rivals, in terms of basic ingredients of life in this country, the proposal to establish Social Security close to 6 decades ago, and I do not know that we have had any such comprehensive proposal since then.

Clearly, we have a major problem. There are many pluses to our health care system. Its costs are growing too fast, too many people are left without coverage, many others left with uncertainty, wondering what will happen with that basic ingredient of daily life.

And I think the President's proposal, which is designed to control costs and use some of those savings to make sure that we have universal coverage, to reduce private-sector costs which have been escalating very rapidly and also to use some of those savings for reducing the Federal deficit is very important. It is a proposal which deals with lifelong health care security for all, universal participation and very comprehensive cost control.

So I commend you on this. Clearly, it builds on the current system, which is employment-based, fills gaps, requires all businesses to offer coverage, requires cost-sharing between business and individuals and government and individuals in certain cases and, in

certain cases, cost-sharing between government and private business.

This committee—I know there are many committees claiming various facets of jurisdiction—this committee does not have any direct jurisdiction over the plan, but we clearly are affected by what happens. Because what happens with health care has a major impact on what happens with the Federal budget in the near term and in the long term. So the focus of this hearing today is dealing on not our jurisdiction as it relates to your bill, but on the impact of what happens on this issue and this committee in the years ahead.

As I look at your plan—and we are curious, I am really concerned about how the numbers fit. As I look at it, there are certain basic assumptions, and it is sort of a revolving circle. I assume that universal coverage is key to cost containment. On the other hand, cost containment is key to universal coverage. And I am curious at how you arrived at your final assumptions on what we can achieve in cost containment. As I understand it, you arrive at a target on insurance premium increases of CPI plus population, which—if it is a goal we can achieve—would be a great accomplishment. I am curious how you got there.

The other key assumption to achieve universal coverage is cost-sharing between employers and individuals and government and individuals. Again, we are curious, both as to the actual numbers involved and how you arrived at your formula for cost sharing. We are interested, in other words, I guess in the totality of your numbers and how they fit.

While I have that interest as someone who Chairs this committee, I also have concerns as a representative of a particular district from a particular State. And that is how you deal in your plan with States who have done a better job than others in terms of offering quality health care at lower cost. And we think that is where we are in Minnesota. We want to ensure that we are not treated unfairly because both the private and public sector in our State have over the years done not by a long shot a perfect job but a better job than other places in this country in dealing with the health care question.

So we want to be sure that the numbers involved work. I can think of no greater tragedy than putting a system in place and then having it fall apart in a year or 2 simply because the numbers did not fit or weren't accurate, and we have to start all over.

[The prepared statement of Hon. Martin Olav Sabo follows:]

PREPARED STATEMENT OF HON. MARTIN OLAV SABO, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF MINNESOTA

Good morning. The House Budget Committee is in session for a hearing on the budget impact of President Clinton's health care proposal. We will have two witnesses from the Department of Health and Human Services—Dr. Judith Feder, the Principal Deputy Assistant Secretary for Planning and Evaluation and Dr. Kenneth Thorpe, the Deputy Assistant Secretary for Health Policy. Dr. Feder had a previously scheduled engagement and will join us in a few minutes.

Most Americans feel we have the best health care system in the world. We have the finest technology and the world's best doctors and nurses. People come from all over the world to receive care at our great universities, hospitals, and clinics. So, what's the problem that makes us want to change it?

The problem is that too many people in our country do not have access to this great care. Too many people have no health insurance either because they can't af-

ford it, their employer doesn't provide it, or they have some type of illness that makes them uninsurable. In fact, today 37 million Americans have no health insurance and many more have inadequate insurance for their needs. And the system has gotten so expensive that most people cannot afford to pay for adequate health care without insurance.

These are the problems the President is trying to fix. The President's Health Security Act is a bold, comprehensive package designed to meet the challenge of providing all Americans with affordable, life-long, high-quality health care.

There is no question that it is time to act. But we the Congress and the people—must have the best information available before we act.

We cannot proceed unless the numbers fit. We must be sure that we have accurate estimates of the costs of achieving this ambitious goal. And we must know that we can afford it.

Long-term reduction in federal deficits must be a part of the plan, as well as long-term savings for the private sector. Without effective cost containment, health care spending will keep on growing. Clearly, for this plan to succeed we must control health care costs.

A key to the Administration's plan is its assumptions on cost containment. How did the Administration arrive at its long-term target of CPI plus population growth for the growth in health care costs?

A second element that is necessary to achieve true universal coverage is cost sharing. This proposal requires all employers to provide coverage and all individuals to acquire coverage. And it sets out a formula for business and government to share the costs with individuals in paying for that coverage. How did the Administration arrive at the cost-sharing assumptions in its package?

The Administration is asking everyone to control costs as if we were on a level playing field. Are we really? How do we deal with the questions of equity this produces? For instance, some states have done a good job on health care and kept costs down, but because of the regional nature of this proposal people in those states could end up subsidizing states that did not hold costs down? Is this fair? How does the Administration justify this?

Apart from the large budget questions, there are many other questions about the plan. People need to know more about how it will work. Particularly, people need to know how this plan affects them.

I am happy to say that the information now being made available by the Administration addresses these concerns in some detail. I hope that this hearing and other forums like it will help lay out information so that people can have their questions answered.

I support the goals of the President's plan. I want it to succeed. Excellent as our health care is, it costs too much and the cost is rising. A national guarantee of universal health care is a goal that we must strive to achieve. It is essential to the future well-being of our country.

Chairman SABO. Before I introduce our witnesses, let me call on Mr. Kasich, if he has any opening comments.

Mr. KASICH. Thank you, Mr. Chairman.

I want to first of all say that, starting back in 1989, I had, when I wrote my first budget against the budgets of the Democratic Committee and the President, who was a Republican, in 1989 it was apparent to me that we needed to have health care reform. And I think it was in 1990 I wrote a letter to Bob Michel and Speaker Foley saying we needed to have health care reform because we cannot hope to control Federal spending, the deficit and everything else unless we have some health care reform.

And, you know, I think it is a great thing that you got the issue on the table, you have made it part of the agenda. But my concern about it, of course, is that what we do in health care reform is something that helps us with our deficit problems, and I hate to have to go back to a few charts, but I have to.

The first one I want to bring to your attention and to the Chairman's attention, because—and I want to thank the Chairman for agreeing to have the meeting today for the simple reason that this is all really budget-related. This is what we have done with Medi-

care Part A. We have projected in 1966, where the black line is, where it started. And we said that in 1990—I don't know if you can see this, Doctor—but that the increase in Medicare would basically be about two inches of that chart. That is what the government projected was going to happen to Medicare. Medicare is actually up here.

Now that shows that whether you are a Republican, whether you are a Democrat, whether you run OMB, whether you don't, whether you control CBO, whether you don't. You don't know what you are talking about. You might as well just put a blindfold on and stick on finger on the map to determine where you are going to go on vacation, and that is essentially what we did on Medicare. And it is a 640 percent margin of error.

Now, the Clinton people said that you were going to try—and this is where I welcome the plan. But what Clinton said was, the President said that what he wanted to do was to reduce the increase in health care spending in an effort to control the deficit. But we took your numbers, and we put them together.

The blue line represents the baseline. If we did nothing, if we did absolutely nothing with health care, the blue line represents the growth in health care spending. What I am shocked by, frankly, is that, under the Clinton plan, we actually increase Federal spending on health care, all areas of health care that the Federal Government is involved with, Medicare, Medicaid, veterans, the whole deal shows that, under the Clinton plan, contrary to what has been said about reducing the amount of money we spend on health care, it escalates faster than the baseline. This chart basically says if we did nothing, we would be better off with the Federal deficit.

Now, you also said—you made projections on what your deficits were going to be. You said that the blue line represents the Clinton projections. The brown line represents what is actually happening.

Now, we adjusted for one thing in here to be fair about this. You see, one of the provisions in your plan says that, because we are going to have lower health care costs, employers are going to make more money. Therefore, they will pay more taxes. And employees are going to get higher pay raises. So, therefore, they will pay more taxes. That is what we used to call voodoo economics. You will not get that scored by CBO. We took the \$71 billion out. If we put the \$71 billion in, it would make somewhat of a difference but not a big difference.

But this is where the proof is in the pudding. You folks argued that the deficit was going to decline like this. The reality is that, using your numbers and what is currently happening, is that the deficit gets wider. This is, I guess, what you would call the Clinton budget deficit credibility gap, right here. And these are not—these are using your numbers. We didn't make these numbers up. These are using your numbers.

So we have basically three problems. One, we couldn't project where Medicare was going to go, not a Democrat, not a Republican. Then you say you are going to slow the growth in Federal spending, and you are worse in the baseline. Thirdly, you say you are going to use this health care reform to reduce the deficit, and the gap gets wider. So the way I look at it, that is kind of like one, two, three strikes, you are out.

And then in your plan you have what is called caps. You say—just forget the global budget debate. But you have a cap on premiums paid by individuals, say an individual not paying more than a certain amount. You say there is going to be a cap on what small business pays. You say there is going to be a cap on the premiums paid by large business. And then you say that when you put these caps on the government will make up the difference with a subsidy. But then you come and you put a cap on what the government can pay.

Now that would be bad enough, except that you also add three benefits. You add early retirees, 55 to 64. All of these people are going to be dumped out of the businesses and covered by the Federal Government. You have a long-term care part of your plan, and you also have a new drug benefit. So you cap all of these things, including capping what the Federal Government pays, and then you add more benefits to it. Your health care spending is going up. Your deficit is widening.

You know, I guess really the bottom line is that I don't quite understand how this is going to solve any of our problems. I mean, it just doesn't seem to make much sense in terms of any way you look at this thing. So what I think we have to do is we have to sit down and work this thing out so that Republicans and Democrats who have been concerned about health care spending could write a plan, and I want to work with you on it.

Under your plan you can see that your proposed U.S. Government-run health care plan is going to be larger than the entire GNP of Canada and who knows how much more larger than the Department of Defense.

But the charts are illustrative of the problem that we have, Mr. Chairman. I think what we are doing under this health care plan, from what I can see here, is we are aggravating the deficit, not solving it, and that is what my great concern is, and I think the charts kind of speak for themselves.

Thank you, Mr. Chairman.

Chairman SABO. Thank you, Mr. Kasich. I am sure our witnesses can respond to your questions, but, clearly, a good number of the charts that I have seen would indicate the plan has a significantly different impact on what happens, both on the Federal budget and as it relates to total costs. Clearly, we have had health care cost escalation far beyond expectations of the government of the early 1980's and the government of the 1970's, and generally we sat by and did nothing.

The problems escalated even more rapidly in the 1980's than what was happening in the 1970's. Clearly, in the early 1980's, we made certain decisions here which reduced governmental involvement in health care planning. I am not sure that is related to what happened, but I am curious about it.

So we look forward to your testimony. We want the numbers to be accurate. We want them to be right. But we also know that if we do nothing the cost of health care is going to drive the deficit on the Federal level but, probably even more importantly, drive private-sector health care costs to a place where we are non-competitive in the world economy. And I think we constantly have

to measure what is proposed against what will happen if we do nothing.

We are pleased this morning to have as our leadoff witness Dr. Judy Feder, who is the Principal Deputy Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services.

And, Dr. Feder, let me publicly thank you for coming to Minnesota for a health care forum, as you clearly are one of the leading experts in Washington on the question of health care reform and have been for many years and are one of the chief architects of the President's plan that we have before us now. We look forward to your overview of what the plan is and how it will impact the economy and the Federal budget in the years ahead.

Before I call on Dr. Feder, she is accompanied by Dr. Kenneth Thorpe, and let me ask our colleague, David Price, to make a few words of introduction.

Mr. PRICE. Mr. Chairman, since one of our witnesses this morning is a constituent of mine, I would like to add a word of introduction and welcome to Ken Thorpe, who is Deputy assistant secretary for Health Policy with the U.S. Department of Health and Human Services. Ken is a nationally known health economist, and he is currently working with the White House to develop and interpret and promote the President's health care reform initiative.

Dr. Thorpe is on leave from the School of Public Health at the University of North Carolina at Chapel Hill, where he has been an associate professor in the Department of Health Policy and Administration since 1990. Prior to joining the UNC School of Public Health, he was an associate professor of health policy and management at the Harvard University School of Public Health and a director of a health care financing and insurance program at Harvard. Dr. Thorpe also has been an assistant professor at Columbia University School of Public Health.

During the past few years, he has served as a member of the Institute of Medicine's panel on the future of employer-sponsored health insurance benefits, the Advisory Council on Social Security's technical panel on the future of income security in Medicare and the New York State Universal Health Insurance Advisory Council. He has also been a consultant for the National Leadership Coalition for Health Care Reform and the U.S. Bipartisan Commission on Comprehensive Health Care. That is the well-known Pepper Commission.

Dr. Thorpe holds his doctorate in policy analysis from the Rand Graduate School, and he has a master's degree in public policy from Duke University and a Bachelor's Degree in political science from the University of Michigan.

He is one of our Nation's most distinguished policy analysts in the field of health care. The administration is fortunate indeed to have him serving at this critical juncture, and I am pleased to welcome him here today.

Chairman SABO. Thank you.

Dr. Feder.

STATEMENT OF JUDITH FEDER, Ph.D., PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND KENNETH THORPE, Ph.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH POLICY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. FEDER. Thank you, Mr. Chairman. It is a pleasure for both of us to be here this morning. It was also a pleasure to be with you in Minnesota. I look forward to future opportunities to work with you, both here and in your home districts to make comprehensive health reform a reality.

You indicated in your opening statement the urgency of health reform. The fact is that we cannot continue on our current course, that the worst action we could take is inaction, to do nothing.

And I would like to begin my remarks by reminding all of us why it is that we are proceeding on health reform, comprehensive health reform now. It is the President's view that it is urgent to proceed on comprehensive reform, not only to deal with the human problems of those who are unable to get health care when they need it but also to deal with the fiscal instability of our current health care system.

We cannot talk today about family budgets, business profitability or the stability—the fiscal stability—of any level of government, local, State or Federal, without addressing the issue of health care costs. And we cannot address that problem unless we proceed on a comprehensive solution, one in which everybody participates and everybody pays their fair share. To do otherwise would leave us in a system in which one payer, whether it be public or private, continues to be able to shift costs from one to the other without achieving either security of coverage or a stable, affordable system.

The President's health security plan would guarantee us a comprehensive reform in which everyone participates and everyone does their part. The proposal seeks to fix what is wrong with our health care system and preserve what is right. It seeks to strengthen all elements of that system so that those Americans who fall ill and those who want to preserve and improve their health can rely on a high-quality system that is affordable, portable and permanent.

Our job this morning is to tell you how we are going to do that. I am going to give you an overview of the overall plan, and then Dr. Thorpe will present to you its financing.

First, as the chart we have just put up shows, under the President's plan, we are proposing a private comprehensive system. Seventy-six percent of the financing for the nonwelfare, nonmedicare payments will come from employers, employees and other individuals making their contributions to the cost of coverage. The remaining 24 percent will come from government.

[See Chart 2 on pg. 28.]

Again, as I said, Ken will elaborate on the financing and the detail you have requested in a moment. Let me give you the overall structure.

The President has laid out six principles that are at the core of our proposal and must be at the center of any health reform bill

enacted by this Congress. They are security, simplicity, savings, choice, quality and responsibility.

If any of these principles is dominant, it is security. Under our current system, no American has true security. Most workers who lose their jobs lose their insurance. People who change jobs often lose their insurance or almost certainly have to change their coverage. Families stricken by illness face the added burden of trying to make sure their coverage won't disappear, and conscientious businesses and individuals who attempt to buy insurance are priced out of the market.

To solve this problem, the President's plan builds on the existing structure of health insurance but makes sure that all of our citizens are covered by a quality health plan they can afford. To achieve that, the plan asks States to create regional health alliances to help consumers and employers purchase the coverage they need. It asks employers to pay at least 80 percent of the average premium cost for a plan in their area, and it asks workers to pick up the remainder.

Every health plan will offer a comprehensive set of benefits to provide all Americans with the kind of care that our health professionals tell us is best: a package that has strong emphasis on prevention, a package that covers inpatient and outpatient care, a package that offers specialty and primary care and a package that includes mental health and substance abuse treatment coverage to help remove the stigma attached to those conditions.

We recognize these new requirements may pose a challenge for some smaller companies, particularly those that currently do not offer coverage, and that is why we provide discounts for employers that will hold the cost of coverage to no more than 3.5 percent of payroll for small, low-wage firms and 7.9 percent of payroll for companies with 75 workers or more.

The majority of Americans should have no trouble paying their individual share, 20 percent, if they choose an average plan. They pay that much or more today.

But for those with low incomes, people with incomes less than 150 percent of poverty, and an additional cap for people whose costs would exceed 3.9 percent of income. Government would also provide discounts for part-time, part-year or unemployed workers who would owe some or all of the 80 percent share of premium.

There are also discounts for the employers' (80 percent) share for people with incomes up to 250 percent of poverty not counting \$5,000 of their wage income and any unemployment compensation they receive.

To further reduce the cost of coverage, the plan reforms the insurance market to eliminate underwriting practices that weed out the sick and cover only the healthy. No insurance company will be allowed to turn away anyone seeking insurance because of a pre-existing medical condition. And by returning to the historic method of community rating, we will make sure that individuals and small businesses are protected from sharp premium increases.

Together, these changes will result in virtual universal coverage for our population. In contrast, if we do nothing, the number of uninsured will grow from 37 million to an estimated 55 million at the end of the decade or nearly 1 in 5 Americans.

Another important element of security is predictability. Today, no person and no business owner can accurately predict what their insurance will cost them. Under the President's plan, all payers will know in advance what their coverage will cost and be able to plan accordingly.

In order to preserve security and predictability, we must control the cost of health care. Through changes in the competitive market, our plan places restraints on growth that will still allow spending to increase but by an amount that is much closer to the rise in other consumer prices. To ensure that these changes achieve the necessary savings, the plan creates a backstop system of enforceable premium limits to make sure no one will pay more for coverage than is appropriate.

The President's plan extends the concept of cost containment to all payers, public and private, so that they no longer shift costs to each other. By applying reasonable limits to the growth of Medicare, we will curb its rate of growth, and we will put those savings back into services such as a new prescription drug benefit in Medicare. Without such coverage, many of our senior citizens are delaying the purchase of prescribed medications, changing their dosage to make prescriptions last longer and even trading unused portions of prescriptions among neighbors.

The President's plan also ushers in a new era for our Medicaid population. They, too, will have health security cards that will make them indistinguishable from any other American. They will enroll in a mainstream medical system that gives them the same benefits enjoyed by everyone else, plus additional services traditionally provided through Medicaid to enable them to use the health care system.

We all know that the current system is too confusing, too intimidating and too expensive. We force our health professionals to waste their time filling out multiple forms and filing multiple claims. The President's plan will do away with the more than 1,500 often conflicting claims forms now in use and substitute a single form that will be easy to understand and easy to complete.

Another key to security is simplicity. The system we propose will make it easy for consumers to gain access, get the care and counseling they need and go on with their daily lives. It is structured from the consumer's viewpoint, to put consumers back in charge of their health care. It is a clear and concise system that, for most people, won't be much different than the way they get health care now, just that it will be guaranteed and with ready access.

An important element of that system will be the new health alliances. They will provide consumers and business owners real clout in the often daunting negotiations with insurers. Through the alliances, small firms and individuals will gain access to high quality coverage at the same price as big firms and under the same rules.

The alliances also will guarantee that it is people who choose their health plans, not employers, by making sure that a variety of plans are available, including at least one—and perhaps more than one—fee-for-service plan and a point of service option in every part of the country.

Once coverage is purchased, the alliances become consumer protection watchdogs that help with any questions or problems that arise.

Once empowered, consumers and businesses in a private system must be ready to take responsibility for their coverage and their care. The President's plan offers Americans a great deal, and, in return, it asks us all to play our part.

Now, I will turn to Dr. Thorpe, who will explain the financing of the system the President proposes.

Chairman SABO. Thank you, Dr. Feder.

Dr. Thorpe.

Dr. THORPE. Thank you, Mr. Chairman, members of the committee, Congressman Price for that kind introduction.

I must say that not only am I constituent but I am a former student of Professor Price when I was at Duke. I know that it has been a loss to Duke but certainly a gain to the Congress to have Mr. Price serving up here in Washington. So thank you for that kind introduction.

I am pleased to be here today to discuss with you the financing of the President's health security act and its impact on the budget. There are two points I would like to underscore with my testimony.

First, as Dr. Feder has already pointed out, the health security act builds on the current private, employer-based health insurance system. Second, and I will spend a substantial amount of time on the second point, our assumptions in developing the estimates, I believe, are very conservative.

Related to that, as you will see throughout, much of our estimates have been based on literally two decades of very extensive academic empirical research, looking at, examining, documenting the costs associated with providing health insurance to uninsured individuals. So this builds on literally dozens of studies in the academic research literature looking at the cost associated with providing coverage to uninsured individuals.

The first point. Just as today, a majority of Americans will have a portion of their health insurance premiums financed by their employers.

Throughout my discussion, I will be referring to a series of charts which I believe have been passed out to members. As you can see from Chart 1, entitled Source of Revenue for Premiums, it does illustrate that fully 59 percent of the premium dollars come from employers, families would contribute 17 percent of total premiums, government discounts for small businesses and low-income families would constitute the remaining 24 percent.

In response to consultations with the Congress and others, we have made several changes to the financing of the plan to guarantee fiscal responsibility and ensure the availability of necessary revenue before the addition of new benefits or programs.

First, extended phase-in. The plan extends the amount of time States have to come into the program. States may come in as early as 1996; they must all be in by December 31, 1998.

Second, the new long-term home- and community-based care program is now phased in over the 1996 to 2003 time period.

In addition, we have increased what I will term a cushion to our basic estimates of the discounts to small firms and low-income indi-

viduals. When we originally calculated the discounts funding, we added a contingency as a safeguard. We increased this cushion from 10 percent to 15 percent to create a stronger safeguard that sufficient funds will be available with the capped entitlement.

We estimated the increased amount of discounts needed under several scenarios, including, first, if the economy were to suffer significant downturn and if companies were to reduce their work force to qualify for additional discounts. The cushion that we have included in our estimates in the legislation has proved to be more than adequate to withstand either of these scenarios, in tandem, or individually.

Even without the cushion, we made several very conservative assumptions in developing these estimates. Let me give you just three examples of the many that we have made in our modeling efforts.

First, we had different estimates of the premium costs associated with providing our comprehensive benefit package from government as well as from outside sources. Within our government estimates from the Health Care Financing Administration and the Agency for Health Care Policy Research, we took the highest premium estimate.

Second, we estimated discounts for small employers using a threshold of employers with less than 100 employees, even though the policy only provides special protections to employers with 75 or fewer employees, thereby overestimating the amount of discounts that flow to small employers.

A third example. Even though dual-earner families with one worker in a corporate alliance, the other worker in a regional alliance, have a choice of which alliance to join, we have estimated that all of these families would choose the regional alliance. Corporate alliances are not eligible for subsidies. They must self-finance discounts for low-income workers. Therefore, we maximized the amount of discounts available to these dual-earner families.

Those are three examples; others are a little bit more esoteric. On top of that base estimate we have added an additional 15 percent each year for an additional cushion to make it even more conservative.

The second thing that I want to point out is the internal review process we used to develop these estimates. A number of departments and agencies have participated in the development and the review of the estimates underlying the President's health reform legislation. A team of actuaries and economists from the Executive Office of the President, the National Economic Council, the Council of Economic Advisors, the Office of Management and Budget; within HHS, the Health Care Financing Administration, the Agency for Health Care Policy and Research, and my office, Planning and Evaluation.

In addition, we have had participation and estimates looked at internally, verified line by line from economists and others in the Treasury Department, in the Labor Department, and, as I am going to talk about in a minute, outside private, not-for-profit think tanks and consulting firms.

We also did something that is, to my knowledge, unprecedented. We had an outside external review of the process, the methodology and the assumptions which underlie our estimates.

As you know, the normal course of business in the Federal Government is to develop budget estimates internally. However, we all view that health reform is too important to proceed on a business-as-usual basis. Therefore, we used an unprecedented process of external review. We organized an outside group of actuaries and health economists from nationally recognized health and accounting firms and Fortune 500 companies. During our model building and estimating process we solicited their analyses, their suggestions, and we took, with few exceptions, their suggestions into consideration and implemented them, as I mentioned, without exception.

I want to make one other point along this line. In addition to internally developing estimates of this plan within the Treasury Department and HHS, we also had estimates done by what I think is probably the most respected not-for-profit, private research group in the country that has a long history of doing these estimates. In fact, they have developed most of the methodology which underlies what we do in government as well as what the Congressional Budget Office does, and that is the Urban Institute.

All through this process, we have had them developing estimates for us on the discount cost of this program. We have worked with them as an external check. We have made sure that our estimates internally were in line with what the Urban Institute estimates were. And I can say with great confidence that the numbers that you will see today are almost precisely the numbers that this private, not-for-profit research group has also produced.

I think that members of the committee well know the reputation of the Urban Institute for developing such estimates.

I would like to go now to an overview of the estimates, and let's spend a little bit of time on Chart 2, which is entitled Financing Health Care Reform.

[See Chart II-A on pg. 84.]

It is broken into two sections: sources and uses. I will start with the sources of funding.

First, Medicare savings. As you can see, during the budget window that we are looking at between 1995 and the year 2000, we have projected about \$123.4 billion in savings to the Medicare program. The specific programmatic changes that the President has proposed are laid out in detail in the legislation.

Let me summarize where the savings are coming from. Twenty-three percent of the savings are coming from proposals that are extensions of expiring authorities such as the Medicare secondary payer provisions. Thirty-four percent of the proposals are funds currently paid to providers who serve a disproportionate number of low-income persons. Universal coverage renders this spending duplicative.

Just so that we are aware, Medicare is expected between 1996 and the year 2000 to grow at about 10.8 percent per year. That is, the President's proposed savings would bring that rate of increase down to 7.4 percent per year. If you included the prescription drug

benefit spending in the Medicare total, that number would be 8.4 percent per year.

We also have for you summarized on the more detailed table where the savings are with respect to Part A, Part B of the program.

Medicaid, is the second bank of savings. We have a substantial amount of detail there, but let me just summarize the biggest items that are there. First, the savings come from the Medicaid cash assistance recipients being covered through the alliance. The main reason is that there are lower growth in the outyears spending for the cash assistance population. We projected this to be about \$22.3 billion in savings.

The second source of Medicaid savings has to do with phasing down what we currently pay for disproportionate share payments. That is \$54.5 billion worth of savings.

There are some other additions in there shown as negatives that we can discuss during the questions if we so choose. They basically have to do with, in part, moving the Medicaid program from a pay-as-you-go basis to a premium-based program which would entail some payment lags and some administrative costs associated with it.

Down to the third bank, which is laid out as a tobacco tax and corporate assessment. With respect to the tobacco tax, the Federal excise tax on cigarettes will be increased by 75 cents per pack to 99 cents per pack effective October 1, 1994. Comparable increases on other tobacco taxes will also be included. The Treasury Department has projected that that will increase revenues by \$65.3 billion.

Second, with respect to the corporate assessment, an annual 1 percent assessment on total payroll will be levied on firms that provide health insurance through corporate alliances. The assessments will be effective January 1, 1996, are projected to raise \$24.1 billion through that.

Mr. SMITH OF MICHIGAN. I am sorry. That is an assessment on what?

Dr. THORPE. Assessment on firms that provide health insurance through corporate alliances, here being defined as firms of 5,000 or more workers.

The fourth bank is a line of other Federal savings, and you will see that there are some associated footnotes there. They come primarily from the VA, DOT and the Federal Employees Health Benefit Plan. The primary source of the savings have to do with the fact that the rate of increase in what the Federal Government spends for those health care programs will grow at a slower rate under the President's proposal relative to baseline. That is reflected in our projected savings.

With respect to the VA, those are reductions in Federal payments that would be offset by new receipts to the VA system since the VA will now be its own alliance, if you will, now open to have veterans as well as their families and employers making contributions into the system. And the VA has made some projections with respect to what those dollar flows on the private side would be.

[The information follows:]

Chart 1
Financing Health Care Reform
Uses of Funds (billions of dollars)

	Fiscal Years									
	1995	1996	1997	1998	1999	2000	1995/2000			
Public Health/Administration	3.6	5.3	5.9	5.8	5.3	5.4	31.1			
WIC Enhancement	0.0	0.5	0.6	0.6	0.7	0.7	3.1			
New Public Health Initiatives	0.4	1.5	2.6	3.3	3.7	3.8	15.3			
Net Spending on Acad. Health Ctrs. and Medical Education	0.0	2.2	1.4	-0.1	-0.1	-0.2	3.2			
Total Spending	5.9	6.3	6.7	8.0	9.5	9.6	46.0			
Less Current Medicare Funding	-5.9	-3.6	-3.6	-3.6	-4.0	-3.9	-24.6			
Less Premium Offset	0.0	-0.5	-1.7	-4.5	-5.6	-5.9	-18.2			
New Federal Administrative and Start-Up Costs	3.2	1.2	1.3	1.8	1.1	1.1	9.6			
Long-Term Care	0.0	5.7	9.3	12.7	16.5	20.6	64.7			
Net Home Based Care for the Disabled	0.0	4.5	7.8	11.0	14.7	18.7	56.7			
Total Spending	0.0	6.9	11.2	14.7	18.7	23.0	74.5			
Medicaid Offset	0.0	-2.4	-3.4	-3.7	-4.0	-4.3	-17.8			
Liberalized Medicaid Eligibility	0.0	1.0	1.0	1.0	1.0	1.0	5.0			
Tax Incentives for Long-term Care	0.0	0.2	0.5	0.7	0.8	0.9	3.0			
Medicare Drug Benefit	0.0	6.8	13.5	14.2	15.2	16.2	85.8			
Benefits, Administration, and Pharmacists Costs	0.0	8.2	16.3	17.5	18.7	20.0	80.8			
Less Rebate	0.0	-1.6	-2.8	-3.3	-3.5	-3.8	-15.0			
100% Tax Deduction for Self-Employed Health Insurance	0.5	0.6	0.9	1.7	2.9	3.1	9.7			
Premium Discounts (Subsidies)	0.0	7.3	18.4	47.6	44.4	43.2	161.1			
Premium Discounts (Subsidies) -- Net of Cushion	0.0	5.7	13.9	35.6	31.7	30.1	117.0			
Capped Entitlement for Premium Discounts	0.0	10.3	28.3	75.6	78.9	81.0	274.1			
Total Discounts (Subsidies)	0.0	12.8	35.7	96.3	100.6	103.6	349.0			
■ Employers (net of cushion)	0.0	3.9	10.9	27.9	28.3	28.6	99.6			
■ Non-retired Households (net of cushion)	0.0	6.0	16.7	43.7	45.5	47.3	159.3			
■ Retirees -- low income subsidies (net of cushion)	0.0	0.9	2.6	6.9	7.2	7.4	25.0			
■ Retirees -- added subsidies (net of cushion)	0.0	0.0	0.0	3.0	4.2	4.4	11.6			
■ Out-of-Pocket Subsidies	0.0	0.3	1.0	2.6	2.7	2.8	9.4			
■ Total 'Cushion'	0.0	1.6	4.5	12.2	12.7	13.1	44.0			

Financing Health Care Reform

Uses of Funds (billions of dollars)

(continued)

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Less Offsets	0.0	-5.5	-17.3	-48.5	-56.2	-60.4	-187.9
States' Required Maintenance of Effort	0.0	-2.5	-7.4	-20.7	-21.7	-22.6	-74.9
Discontinued Medicaid Coverage	0.0	-2.0	-6.9	-19.8	-26.5	-29.8	-85.0
■ Basic Benefits	0.0	-1.9	-6.5	-18.5	-24.7	-27.9	-79.5
■ Net Wrap-around Benefits	0.0	-0.1	-0.4	-1.3	-1.8	-1.9	-5.5
Medicare Offset for Employed Beneficiaries	0.0	-1.0	-3.0	-8.0	-8.0	-8.0	-28.0
Total Spending	4.1	25.5	48.1	82.0	84.3	88.4	332.4
Deficit Reduction	11.0	2.1	-3.4	-8.1	20.2	35.8	57.7
TOTAL	15.1	27.6	44.7	73.9	104.5	124.3	390.1

On the other revenue effects, let me try to summarize those quickly. This is something that, clearly, the Treasury Department has much more detail on, but let's go through the largest items here on the other revenue effects.

The first one has to do with the effects of an employer mandate, cost containment and subsidies. What this is projected to be is a \$23 billion increase in receipts into the Treasury, largely due to the fact that health insurance premiums under the President's plan are going to grow at a slower rate relative to what they are projected to grow. That slower rate in health insurance premiums would be reflected in either increases in cash wages or increases in corporate profits, both of which are taxable. There would be a rise then in tax receipts associated with that. The calculations that the Treasury Department has used to develop this are based on standard estimating conventions that both Treasury and I believe the joint tax committee use to develop such estimates.

The second piece of \$30 billion has to do with excluding health insurance from cafeteria plans. That would be effective as of January 1, 1997. Employer contributions for the comprehensive benefit package will continue to be excluded from income for purposes of calculating individual income and employment taxes, but contributions of individuals to cafeteria plans will no longer be treated as tax-free. Those will be treated now as taxable income under the provisions that we have outlined.

The third big piece in here has to do with a note here that says assessment on employers for retiree subsidies, which is going to raise \$11.4 billion in revenue. As you are aware, the President's plan proposes to have the discount pool assume responsibility for the 80 percent piece of the premium that retirees and nonworkers would have had to have paid out of unearned income. That provision comes into effect January 1, 1998.

What this component of the revenue effect does is apply an assessment on companies that benefit from this provision. In essence, it is an assessment that would be levied on corporations that have reduced payments as a result of this.

The precise calculation—just going to my notes on it so that we are clear—is that in each of the 3 years listed here employers will pay 50 percent of the greater of, first, the amount that firms would have paid for covering their early retirees in the absence of health care reform, and, second, the annual average of the actual early retiree health benefits paid by the employer during the period of 1991 to 1993. This would be adjusted for medical cost inflation. This assessment would apply to both private and government employers.

As you will see, there are a series of other ones that have to do with tax incentives for health providers in shortage areas and so on, and we can provide whatever level of detail on those areas that you would like to receive.

Moving to the next page, under Public Health/Administration, the President's plan is proposing a substantial expansion within the Public Health Service here listed as a total of \$31.1 billion. I should be clear that that includes both public health as well as new administrative costs. I believe that the public health component of this is approximately \$18 billion.

Let me give you some sense of what those public health initiatives are. They include an expansion of capacity, including an expansion of community health care centers. There are monies in there for work force development, including expansion of the National Health Service Corps and health professions. There are new monies for school-based clinics in the proposal. Most needed as we make major changes in the system, there are new monies for health services research initiatives in the plan as well.

Those are basically the major programmatic areas, and we have a substantial breakdown of exactly what the year-by-year in budget authority outlay estimates are for the public service line items.

You will see WIC enhancement. We are proposing to expand this program to fully cover kids aged 2, 3 and 4. We currently target spending on pregnant women and infants, so this will be a substantial enhancement of the WIC program. We believe fully funding the program over the time period shown here is a \$3.1 billion increase in funding.

The next line concerns new spending on academic health centers and medical education. This is a commitment in the plan to maintain spending to academic health centers, both for what we traditionally have called indirect costs as well as the direct salary costs at academic health centers. This is financed both by current Medicare spending as well as by some premium financing that would go to academic health centers.

The total new spending you can see is \$46 billion over the time period, and it comes primarily from the two sources I have mentioned. One is the existing payments that Medicare makes to teaching hospitals, both for indirect payments as well as direct payments for medical education. Second, a portion of what we pay currently in health insurance premiums would simply be used to finance about \$18 billion of those expenditures.

The last piece of this bank has to do with the administrative and start-up costs. As the system does get up and running, there are going to be some new Federal administrative costs involved with respect to helping to provide the data, the analysis and the infrastructure for health care reform. We have estimated those costs to be about \$9.6 billion.

The second bank has to do with long-term care. There are three basic program elements within long-term care. The first one has to do with our program for home- and community-based care for the severely disabled. As I have mentioned, this is a program which starts in 1996, will be fully phased in through the year 2003.

There are two line items there. One is total spending, which is \$74.5 billion. The second line is an offset to Medicaid. Essentially, this represents severely disabled who are being cared for and are receiving services through the Medicaid program who would now receive coverage through our new home- and community-based care program. The \$17.8 represents the offset, if you will, to existing Medicaid programs for having the severely disabled now receive coverage through the new home- and community-based care program. So the net cost of this we projected to be \$56.7 billion.

There are two other items there within the long-term care bank. The first has to do with liberalized Medicaid eligibility, which is a provision that would increase the asset protection that individuals

have from \$2,000 to \$12,000. That is a State option. That is not a mandatory program. So it is up to the States, if they so choose, to avail themselves of this provision. We have estimated this to be a \$5 billion item.

Tax incentives for long-term care primarily have to do with the opportunity now that individuals would have to purchase long-term care insurance and to deduct the cost of those through an employer, as they do other forms of health insurance today.

The next bank down has to do with the new Medicare drug benefit. There are two pieces here. The first has to do with the costs—the benefit costs and the administrative costs—of the Medicare drug program, which we projected at \$80.8 billion. In addition, however, as you will see in the plan, there is a rebate program that would be developed. Medicare would receive a 17 percent rebate from branded drugs. There would not be a rebate program for generic drugs. So the effects of the rebate program are shown under the less rebate line item, so that the net cost of the Medicare drug program is approximately \$66 billion over this time period.

The last bank has to do with what I started out with in my testimony, which has to do with our estimates of the premium discounts in the plan. Let's spend a little bit of time walking through this so we can understand precisely what is in this. As I mentioned, I spent a substantial amount of time walking us through how we came up with our base estimates, which I think are in and of themselves conservative, and, in addition to that, have built in an additional cushion for contingencies that I talked about during my earlier remarks.

The first line here which shows premium discounts of \$161.1 billion over this time period is the net of two things. First, we projected that our gross discounts, that is the total cost of providing discounts to small firms, low-income individuals, are \$349 billion over this time period.

In addition, however, as you will see from the following page there are a series of offsets to that gross subsidy amount. And there are really two types of offsets here. The first is for Medicare beneficiaries who are currently working. They will now receive their coverage for the time period that they are working and throughout the remainder of their enrollment year in the health alliance. So they, as well as their spouses, will get coverage through the alliance during the time period that they are working. That represents then a direct savings to the Medicare program. That is an offset that we projected at approximately \$28 billion.

In addition, there are two other sources of offsets. One is that there are State savings, if you will, for Medicaid beneficiaries that are now receiving coverage through the alliance. These are primarily the individuals who are currently receiving Medicaid as a noncash beneficiary, so this is not the welfare population. We projected that those savings have to be approximately \$75 billion to States over this time period, and that indeed will constitute their maintenance of effort under the program.

So the easiest way I think to think about the States' required maintenance as a buffer here is simply that States that are currently making payments today for noncash beneficiaries for the covered services in our plan will now simply make those payments

into the health alliance, and those payments into the health alliance will grow at our budgeted rate of increase. So you can see that that truly is simply a transfer.

States are making the payments today. They will simply make the payments into the alliances. Those monies will be used to finance the discounts for low-income individuals within the alliance. So we are counting the \$75 billion as a direct offset, the \$28 billion in Medicare worker savings as a direct offset. And, in addition, there are savings to the Federal Government of \$85 billion for discontinuing their contribution under the noncash program as well, which is listed under the discontinued Medicaid coverage.

So the offsets over this time period total \$188 billion. They are the Federal Medicaid savings, the State transfers into the alliance, and the Medicare worker savings under our policy. So that first line item is, again, the \$161.1 billion represents our best estimate of what the overall total cost would be of the discounts, which are 349 minus these offsets.

If we go to the bottom bank where it says total discounts and subsidies, you can see there that the 349 is outlined there again in detail. That is our estimate of the gross subsidies. What is underneath those is our estimate of what the subsidies are to employers, households and discounts for out-of-pocket spending as well. You will see that each of those are shown without our 15 percent cushion built in. We are showing the 15 percent cushion as a separate line item, which over this time period turns out to be \$44 billion of additional money that we built into our base conservative estimates. So we have broken those out for you separately.

Finally, let me just walk very, very quickly through the final two charts. I won't spend too much time on these, because I think they are pretty self-explanatory.

First, if you look at Chart 3, you will see that there is a total of about \$161 billion in discounts. That traces back to the calculation that I just went through. Just to give you a feel of where these go, approximately 29 percent will go to employers. Families will save about—households will receive about 53 percent directly. You will see that there is some additional discounts available for early retirees as well as out-of-pocket payments. There is a 13 percent—13 percent of the discounts are built into the cushion.

Finally, let me end up by looking at where the discounts go in the employer sector of the economy by firm size. What this chart is showing is our estimate of what the discounts for employers would be if the plan were implemented during 1994. So this is a 1-year estimate of what the discounts would be in 1994. We have estimated that it is about \$22.4 billion. You can see that almost three-quarters of the discounts will go to the smallest employers; that is, employers that have firms with 25 or fewer workers, and you can then see the distribution of where those discounts go by other firm sizes.

So, overwhelmingly, these discounts really are placed at exactly the areas that we were most concerned about and tried to design a structure to make sure that the discounts were focused on small low-wage firms, and you can see that three-quarters of them go there.

[The information follows:]

Chart 3

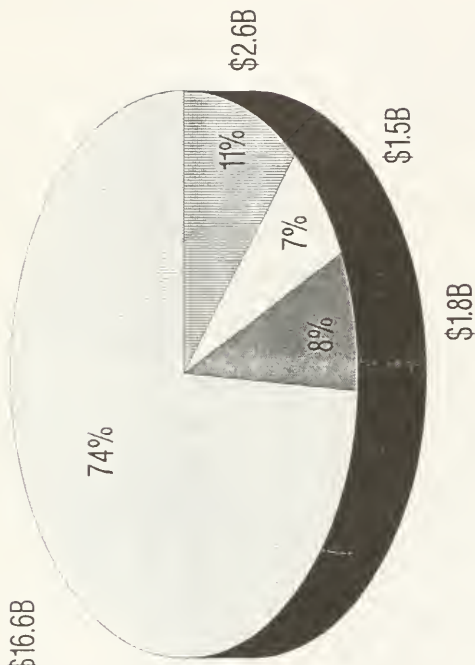
Distribution of Gross Discounts, 1995-2000 (\$ billion)

Type	Amount	Percent
Gross Discounts		
Employer	\$100	29%
▪ Private	98	28
▪ State/Local	2	1
Household	\$184	53%
▪ Non-retiree	159	46
▪ Non-worker discounts to retirees	25	7
Retiree discounts	12	3%
Out-of-pocket	\$9	3%
Discount "cushlon"	\$44	13%*
Total	\$349	100%
Offsets		
Medicare	\$28	15%
Medicaid	\$160	85%
▪ Federal	85	45
▪ State/Local	75	40
Total	\$188	100%
Net Discounts		
Total	\$161	100%

* The cushion is 15% of the premium discounts, or 13% of total discounts

Employer Discounts by Firm Size, 1994

Nearly three-quarters of employer discounts go to the smallest businesses



Total Discounts = \$22.4 Billion

Firm Size:

< 25

25-49

50-99

100+

NOTE: Include all employers subject to 7.9% payroll cap

SOURCE: HCFI

I know this is a very fast initial run-through of a very complex set of tables. We all look forward to working with the committee over the course of the next several months as we develop health reform legislation, and I know Dr. Feder and myself would be happy to answer any questions you may have.

[The prepared statement of Dr. Judith Feder and Dr. Kenneth Thorpe follows:]

PREPARED STATEMENT OF JUDITH FEDER, PH.D., PRINCIPAL DEPUTY ASSISTANT SECRETARY OF HEALTH AND HUMAN SERVICES, AND KENNETH THORPE, PH.D., DEPUTY ASSISTANT SECRETARY OF HEALTH AND HUMAN SERVICES

Good morning Mr. Chairman and members of the committee. It is a pleasure to be here this morning to discuss the President's Health Security Plan. This is indeed a momentous occasion and the beginning of a process that I believe will lead to a better, stronger, and more secure health care system for all of the people we serve.

The President's proposal seeks to fix what is wrong with our health care system and preserve what is right. It seeks to strengthen all elements of the system so that those Americans who fall ill and those who seek to preserve and improve their health can rely on a high-quality system that is affordable, portable, and permanent.

We in the Administration have worked for many months to craft a proposal that addresses the serious deficiencies in our current system. We have consulted with hundreds of experts, including nearly all members of the Congress; we have gone directly to the people of this country to hear their complaints and their hopes.

The bottom line is that the quality of our current system is steadily eroding. You know all too well the fundamental problems: 37 million of our citizens have no health insurance, while another 25 million have inadequate coverage; skyrocketing costs increasingly place coverage and care out of reach for many Americans; our system is weighted down with too much paperwork and too many bureaucrats; many citizens watch helplessly as their health care choices evaporate, leaving them with no say in where they get their care; our quality of care remains uneven, giving the majority of our citizens the best care in the world, but leaving some others with a level of care no better than Third World countries; and employers, governments at all levels, and individuals continue to exercise less responsibility for our national health care system and their personal health care.

The American health care system has lost sight of those who it is designed to serve—the patients. We must change the system so that it is clearly understood and so that it serves all Americans when they need care.

We must get a handle on the cost of health care. We all know only too well the price we pay for uncontrolled health spending. While the overall budget of the Department of Health and Human Services has increased some 229 percent since 1980, almost all of that has been swallowed up by inflation in our health care programs. Medicare spending, for example, has risen 363 percent in the past 14 years. The Federal share of Medicaid spending has increased even more dramatically—526 percent. As a result, health care programs have been the single largest contributor to our federal deficit and have systematically squeezed out resources that could be spent on other important priorities including education, job creation, infrastructure, and economic development.

Rising health costs and uneven health care coverage have also taken their toll on American businesses. Over the last decade the annual amount spent on health care by the average American family has more than doubled from \$1,742 to \$4,296. And that amount will double again by the year 2000 if nothing is done. Even in the last year, as the health care sector has attempted to slow its growth, two-thirds of American companies saw their health care costs rise; only 7 percent saw their costs fall. For many companies, health care costs are the single largest expense they incur; for many others, that expense is so great that benefits have been pared back or even eliminated.

In the five weeks since the President addressed the Congress, we have spent much of our time listening. Listening to the comments and advice of lawmakers here on Capitol Hill and legislators and governors in our state capitals. Listening to those who are in the health care trenches—doctors, nurses, hospital administrators, and others. And listening to the people.

What we've heard has helped us to improve our plan. But let me make one thing clear, the one thing that has not changed is the core set of beliefs that have guided us from the start.

SIX PRINCIPLES

The President laid out the six principles that are at the core of our proposal and must be at the center of any health reform bill enacted by this Congress. (Chart 1) They are Security, Simplicity, Savings, Choice, Quality, and Responsibility. We've seen wide bipartisan agreement on these principles. That's good. Now it's time to begin making them a reality.

Today, I'd like to discuss some of these principles with you, starting with security.

SECURITY

It's not only the 37 million uninsured who lack health care security. They are only the most vivid evidence of this problem. Under our current system, *no* American has real peace of mind. Most workers who lose their jobs lose their insurance. People who change jobs often lose their insurance or have to change their coverage. Families stricken by illness face the added burden of trying to make sure their coverage won't disappear. And conscientious businesses and individuals who attempt to buy insurance are often turned away because the price is out of reach. At the same time, the lack of health care coverage in many low wage jobs frequently traps young mothers in welfare.

To deal with this central concern, the President's plan builds on the existing structure of health insurance that has, for nearly 50 years, provided coverage to workers and their families.

(Chart 2) Under the President's plan, the largest portion of financing for health care premiums—over three-quarters—will come from employers and households through their contributions to the cost of coverage. The remaining 24 percent will come from government.

(Chart 3) We have calculated that the federal share, including our contribution to premiums, public health investment, long term care, and deficit reduction will amount to \$389 billion over the period of 1994 to the year 2000. We will produce that total in the following way: *\$124 billion* will come from savings achieved in the Medicare program. That will bring the annual rate of growth in that vital program more in line with growth in the private sector. Fully half of these savings can be achieved simply by continuing policies adopted by this Congress in the Omnibus Budget Reconciliation Act of 1993 and by reductions in payments to disproportionate share hospitals made possible by universal coverage. Another *\$65 billion* will be saved in the Medicaid program, by enrolling remaining Medicaid beneficiaries in private health plans with lower cost growth and then a similar reduction in the disproportionate share hospital payments. We will produce another *\$40 billion* in savings in other federal programs, including the government employees, military and veterans' health care. Another *\$71 billion* in federal revenue will come as a result of (1) slower growth in tax-exempt health spending that will produce higher wages and taxable profits; (2) excluding health insurance from cafeteria plans; (3) other tax changes; (4) the corporate retiree assessment; and (5) reduction in debt service. And, finally, we gain another *\$89 billion* by increasing the federal excise tax on cigarettes and the one percent assessment on corporate alliances.

How will these federal dollars be spent? The overwhelming majority of these funds will finance premium discounts for small employers, individuals, and early retirees. Another \$66 billion will pay for the new Medicare prescription drug benefit; \$65 billion will go for our long term care initiatives; \$10 billion will pay for tax incentives and deductions for the self-employed allowed under the plan; and \$29 billion will cover our investment in public health and some fairly minor start-up costs. That leaves another \$58 billion in deficit reduction. I must point out to the Committee that we have deliberately built in a cushion of \$45 billion to deal with behavioral effects that cannot be modeled.

UNIVERSAL COVERAGE

A key to security is the assurance that all of our citizens are covered by an affordable health plan. We achieve such coverage by asking states to create one or more regional Health Alliances to serve as the negotiators for consumers and employers. We ask our employers to pay at least 80 percent of the average weighted premium for a plan in each region with workers picking up the remainder. The vast majority of American firms already provide such benefits; in fact, many do even better.

(Chart 4) All health plans will be required to offer a comprehensive set of benefits to provide all Americans with the kind of care that our health professionals tell us is best. A package that has a strong emphasis on prevention. A package that covers inpatient and outpatient care. A package that offers specialty and primary care. And

a package that improves on our mental health and substance abuse treatment coverage and helps remove the stigma attached to these conditions.

(Chart 5) We recognize that these new requirements may pose a temporary challenge for some companies, particularly those that currently do not offer coverage. Our plan provides significant discounts for employers that will hold the cost of coverage to no more than 3.5 percent of payroll for small low-wage firms—defined as those companies with 75 or fewer workers with an average wage of \$24,000 or less—and 7.9 percent of payroll for all other companies.

Individuals will be eligible for discounts as well. For those required to pay the 20 percent share of a health plan premium, discounts will be available for those with income at or below 150 percent of the federal poverty line. Such individuals also will be protected by a limit of 3.9 percent of income on individual contributions. For the nonworking population that get no assistance from an employer with premium costs, discounts are available for those with non-wage income at or below 250 percent of poverty. And, finally, for retired workers between age 55 and 65, the federal government will eventually pay the full 80 percent employer share of the premium.

To further reduce the cost of coverage, we will reform the insurance market to eliminate unseemly underwriting practices that weed out the sick and cover only the healthy. We will end the practices of cherry-picking and cream-skimming. No insurance company will be allowed to turn away a person seeking insurance because of a pre-existing medical condition affecting that individual or a member of that family. Nor will insurers be allowed to continue pricing those who are sick or disabled out of the market. We propose returning to the historic method of community rating that served our country well and offered all Americans coverage at a reasonable cost.

(Chart 6) Together, these changes will result in virtually universal coverage of our population. In contrast, if we do nothing, the number of uninsured will grow from 37 million to an estimated 55 million at the end of the decade, or nearly one in five Americans.

During the last five weeks, we have gone over of the numbers in our plan, scrubbed them and rescrubbed them so that we can explain with confidence to you and to the American people how this plan will work. There are no rosy scenarios here, no magic asterisks. These are conservative numbers that will stand the test of public scrutiny.

A key feature of the President's plan is predictability. It will be easy for all Americans to determine the cost of their coverage and the scope of that coverage. Health plans will be required to offer four distinct classes of premiums for each policy: one covering single individuals; one covering couples; one covering single-parent families; and one covering two-parent families.

While the premiums charged by each Health Alliance will differ according to local community costs, we have determined the average national premium for each group in 1994 dollars. The national averages are as follows: \$1,932 for a single person; \$3,865 for a couple without children; \$3,893 for a single-parent family; and \$4,360 for a two-parent family with children.

For those families and individuals who must pay the maximum 20 percent of these premiums, monthly costs will range from a low of \$32 to a high of \$73. As I said, these amounts will vary from state to state and community to community, but these national averages give us a good idea of how reform will change our current system for the better.

For employers, the new system will be predictable as well. According to our estimates for 1994, the *average* undiscounted cost to some employers will be as little as \$1,546 for individuals and as much as \$2,479 for two-parent families with children. With the premium discounts we offer, however, the cost to employers will be considerably lower.

Stable, predictable health insurance expenses will be of great value to business owners—particularly small businesses—who today cannot know with any reliability what their annual costs will be. Under today's system, one illness in one family can devastate a year of financial planning by a grocer or a hardware store owner. This must change—and it will—if we're going to have an economy in which small business can flourish.

SAVINGS

In order to ensure the kind of security I have just discussed, we must control the cost of health care.

In the current year, the United States will spend approximately 14 percent of its gross domestic product on health care. That is far greater than any other industri-

alized nation. In fact, our closest competitor in the health care arms race is Canada, which spends only 10 percent of its GDP on health care. If we do nothing about our costs, health care will rise to 19 percent of GDP at the end of the current decade.

Through changes in the competitive market, our plan places restraints on this growth that will still allow spending to increase, but by a much more reasonable amount—one much closer to the rise in other consumer prices. To ensure that these changes achieve the necessary savings, we will create a backstop system of enforceable premium caps. That way, no company or individual will pay more for coverage than is appropriate.

We extend this concept of savings to all payers of health care—public and private. By applying reasonable limits to the growth of Medicare, we can reduce the rate of that program's growth during this decade even while adding new coverage for prescription drugs.

By applying these limitations, we will expand the Medicare program to include an important new benefit covering the cost of prescription drugs. Numerous studies indicate that, without such coverage, many of our senior citizens are forgoing prescribed medications, independently changing their dosages to make prescriptions last longer, and even trading unused portions of prescriptions among neighbors. All of this is done in the name of saving money; all of it endangers the health and lives of our senior citizens. The end results of our efforts will be a stronger Medicare program that will continue to serve all of our senior citizens.

We also plan to completely transform our Medicaid program for acute care services. Medicaid beneficiaries have suffered too long with a system that offers, in many ways, second tier medical care. Uneven coverage and reimbursement rates have left too many of our needy citizens without coverage. And even those who are in the program are often turned away by health care professionals who refuse to accept Medicaid patients.

Under our plan, we place all of these individuals in a mainstream medical system: They will be enrolled in Health Alliances, which will provide them access to accountable health plans. Each Medicaid beneficiary will get the same health security card as all other Americans. They will receive the same comprehensive benefit package, plus additional services traditionally provided through Medicaid to allow access to the health care system. Non-cash recipients also will gain access to these health plans with accompanying wrap-around benefits that will ensure that none of our neediest children will lose the services they now utilize.

SIMPLIFICATION

Another important element of a reformed health system is simplicity. We have all heard the complaints from the men and women who provide medical care. They tell us that the current system is too confusing, too intimidating, and too expensive. We are wasting time and money filling out forms, filing claims, and flailing at an unresponsive bureaucracy. Nurses and doctors often must take time away from patients to fulfill the demands of some faceless bureaucrat based 500 miles away.

Our new system (Chart 7) makes it easy for consumers to gain access, get the care and counseling they need, and go on with their daily lives. It is structured with the consumers' viewpoint in mind. And from that viewpoint, it is a clear and concise system.

(Chart 8) The Alliances will have important responsibilities but they will not be a new level of bureaucracy that gets in the way of business owners and consumers. Rather they will be a tool to cut through the bureaucracy of private insurance. The responsibilities of the Alliances are clearly specified in the legislation. Some of these are: enrolling individuals in health plans and issuing Health Security cards; transferring premiums from employers and individuals to health plans; providing consumers with information about the quality and cost of health plans; working with health care professionals to develop fee schedules for fee-for-service plans; and serving as an ombudsman for employers and consumers.

The President's plan also assists health care professionals and institutions. We will do away with the more than 1,500 often conflicting claims forms now in use and provide a single form that will be easy to understand and easy to complete. And we will encourage greater use of electronic claims and speed the process of reimbursement throughout the system.

CHOICE

One of the prices we have paid for our current patchwork system has been the loss of involvement of consumers in the choice of their health plan and their medical providers.

Our proposal guarantees Americans a choice of health plans, including at least one fee-for-service plan. In many areas of the country, we expect there to be a great deal of choice. We realize, however, that in some parts of our country such wide-ranging choice may not be quickly available. The President's plan calls for specific efforts to improve choice in rural areas of the country including the creation of new community health centers, a doubling of the size of the National Health Service Corps, provision of technical assistance to those who want to create new health plans, the training of additional mid-level practitioners, and designation of many rural hospitals and other health facilities as essential providers.

But we must remember that the greatest benefit we can provide to the rural parts of our country is universal coverage. Our most recent data indicate that 30 percent of our rural population is uninsured. This creates a tremendous drain on rural communities and the facilities that serve them. That will change.

The guarantee of choice goes beyond health plans. Americans are used to a system that allows them to select their health care professionals. This will be preserved. First, every Health Alliance will be required to offer at least one fee-for-service plan. Second, all plans will be required to offer a point-of-service option that will allow consumers to go outside the plan for services they desire. And, finally, all physicians will be allowed to join multiple health plans.

QUALITY

There is no question that any health care system must be based on high quality medicine and must have built-in mechanisms to measure and protect that quality.

The President's plan calls for the creation of a National Quality Management Program designed to improve access, effectiveness, and appropriateness of care. Working with consumers and providers of care, we will develop national measures of quality performance; develop and improve consumer surveys; and recommend performance goals for the health plans.

In addition, the work now being done by the Agency for Health Care Policy and Research on practice parameters will continue and that information will be shared with all health plans and health care professionals as well as the general public.

RESPONSIBILITY

Finally, no system that we design can work without the participation of all involved. We offer Americans a great deal through our health care plan; in return, we ask something of everyone.

We ask employers to contribute to the cost of coverage for their employees. In return, we make sure that all companies play by the same rules and we give assistance to those who need it.

We ask employees to contribute to the cost of their coverage and to educate themselves about the choices available to them. In return, we provide lasting coverage that moves with them wherever they go.

We ask our caring health care professionals to provide high-quality care to all Americans at a reasonable cost. In return, we eliminate the incidence of charity care, and allow health care professionals to spend their time with patients, not paperwork.

We ask our state and local governments to maintain their current efforts, particularly toward the poor and disabled. In return, we give states the maximum flexibility in designing their systems to meet their local needs.

CONCLUSION

In conclusion, Mr. Chairman, I believe we have come to an historic crossroads. One that allows us, as public servants, to leave behind us tangible evidence of our work and our caring; to fulfill one of the great unfinished items on our national agenda; and to create a sense of lasting security for all Americans on one of the most personal of issues, health care.

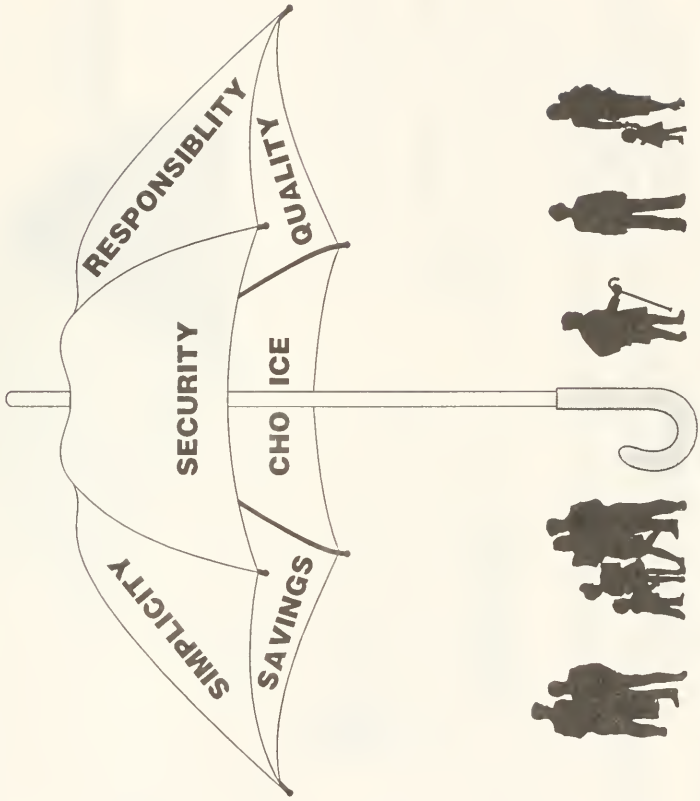
Working together, we can create a system of health care that is secure but not stagnant. One that is simple but not simplistic. One that saves resources instead of sapping them. One that offers choice instead of chance. One that guarantees quality for all, not for some. And one that asks for responsibility while eliminating risk.

We can do this. We should do this. And together I know we will do this.

Thank you.

CHART 1

Principles of the Health Security Plan



Source of Revenue for Premiums

Percent of Public and Private Premiums Under Reform

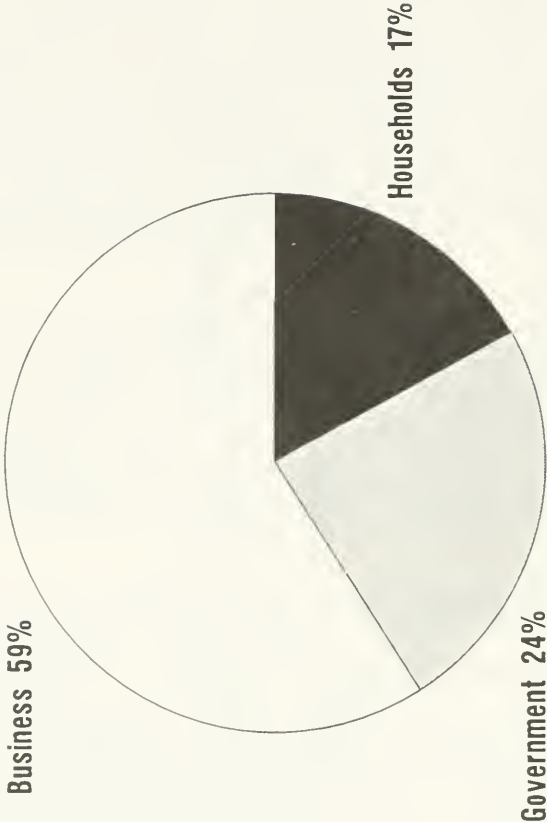
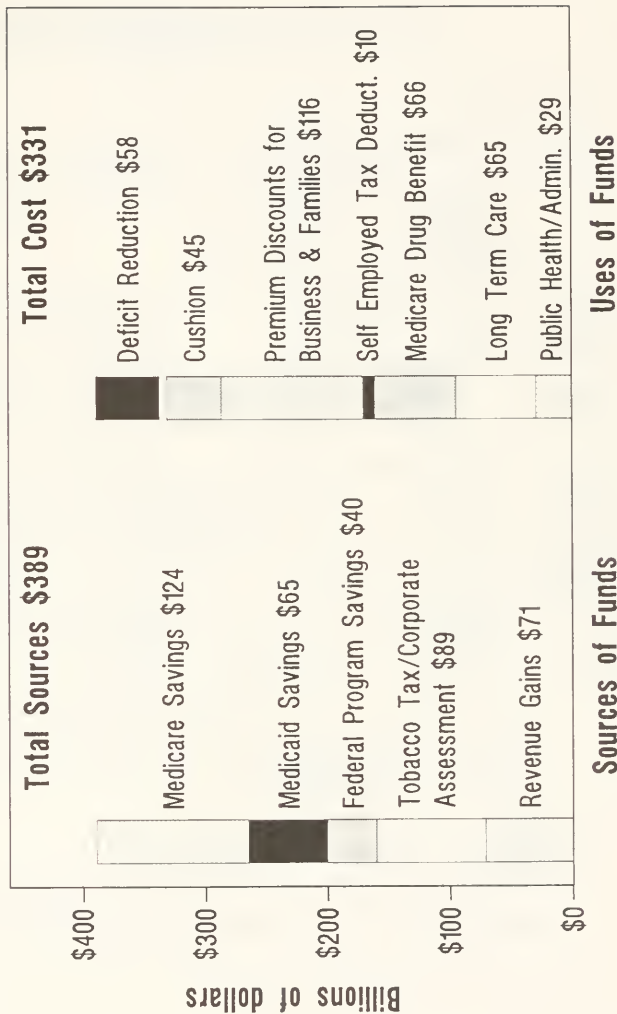


CHART 2

Financing Health Care Reform

Sources and Uses of Federal Funds*



*Seven year totals (1994-2000)

AMFPI/29

CHART 4

**BENEFITS: THE HEALTH SECURITY PLAN COMPARED
WITH CURRENTLY OFFERED PLANS**

BENEFITS	HEALTH SECURITY PLAN		BLUE CROSS STANDARD, FEHBP	FORTUNE 500 COMPANY
	LOW COST SHARING (HMO) / IN-NETWORK COMBINATION PLAN ¹	HIGH COST SHARING (FFS) ² / OUT-OF-NETWORK COMBINATION PLAN		
Medical Plan Maximum	No lifetime dollar maximum limit	No lifetime dollar maximum limit	Lifetime maximum for organ/ tissue transplants, mental health and substance abuse	Lifetime maximum for inpatient substance abuse
Out-of-Pocket ³	\$1500 / individual \$3000 / family maximum	\$1500 / individual \$3000 / family maximum	\$3000 / individual \$3000 / family	\$1,000 per covered individuals - does not include deductibles
Deductibles	None	\$200 / individual \$400 / family	\$200 / individual \$400 / family	\$200/individual \$400/family
Inpatient Hospital ⁴	Full coverage, no coinsurance No dollar or day maximum	20% coinsurance no dollar or day maximum	\$250 per admission deductible No dollar or day maximum	Full coverage in-network; 20% coinsurance out-of- network
Doctors Office Visits, Hospital Outpatient	\$10 copay per visit No dollar or visit maximum	20% coinsurance no dollar or visit maximum	25% coinsurance	20% coinsurance
Outpatient Labora- tory, Radiology, and Diagnostic Services	Full coverage	20% coinsurance	25% coinsurance	Full coverage in-network 20% coinsurance out-of- network
Emergency	\$25 copay per visit, waived in emergency	20% coinsurance	Full coverage within 72 hrs. of accident	Full coverage - required plan notification within 48 hours
Preventive Services ⁵	Full coverage, based on periodicity schedule	Full coverage, based on periodicity schedule	25% coinsurance 100% well child care	not specified

1. SSI and AFDC recipients, and families with adjusted family income below 150% of the applicable poverty level, are eligible for reductions in cost sharing, if alliances determine that there are insufficient numbers of low or combination cost sharing plans available.

2. FFS - fee for service

3. Deductibles counted toward out-of-pocket limits.

4. Mental health and substance abuse have separate provisions, see below

5. Including well-child and prenatal care, periodic health exams, targeted tests and vaccines

6. The National Health Board, in consultation with experts in clinical preventive services, will review and define specific services as preventive services for high risk populations, and will define appropriate periodicity schedules

CHART 4 (cont.)

BENEFITS	LOW COST SHARING (HMO) / IN-NETWORK COMBINATION PLAN	HIGH COST SHARING (FFS) / OUT-OF-NETWORK COMBINATION PLAN	BLUE CROSS STANDARD, FEHBP	FORTUNE 500
Prescription Drugs	\$5 per prescription	\$250/year deductible 20% coinsurance	\$50 deductible 40% coinsurance	20% coinsurance 50% coinsurance for drugs for treatment of mental or nervous conditions
Inpatient Mental Health (MH) and Substance Abuse (SA) ⁷	Full coverage 30 day limit / episode 60 day annual limit	1 day deductible 20% coinsurance 30 day limit / episode 60 day annual limit	\$250 per admission deductible; 40% coinsurance Unlimited days \$3,000 maximum for substance abuse treatment program - 28 day max. \$50,000 lifetime maximum	20% coinsurance pre-certification required Substance abuse: Full coverage in-network 20% coinsurance out-of-network; 30 days per stay; 2 stays maximum
Outpatient Mental Health	All outpatient except psychotherapy - \$10 / visit Psychotherapy - \$25 / visit, 30 visits annual maximum; 4 visits / 1 inpatient day at plan's discretion, beyond 30 visits Intensive nonresidential - full coverage; 120 day annual maximum. Available at plan discretion: first 60 days as trade against inpatient benefit; remaining 60 days subject to plan discretion	All outpatient except psychotherapy - 20% coinsurance Psychotherapy - 50% coinsurance; 30 visits annual maximum; 4 visits / 1 inpatient day at plan's discretion, beyond 30 visits Intensive nonresidential - 20% coinsurance; 120 day annual maximum. Available at plan discretion: first 60 days as trade against inpatient benefit; remaining 60 days subject to plan discretion	40% coinsurance; 25 visits annual maximum - includes partial hospitalization and visits for outpatient substance abuse \$50,000 lifetime maximum	20% coinsurance for employee 50% coinsurance for dependent
Outpatient Substance Abuse	30 group therapy visits subsequent to treatment in inpatient or intensive nonresidential settings For individuals not initially treated on an inpatient or intensive nonresidential basis, 4 visits for 1 inpatient day trade	30 group therapy visits subsequent to treatment in inpatient or intensive nonresidential settings For individuals not initially treated on an inpatient or intensive nonresidential basis, 4 visits for 1 inpatient day trade	Subject to mental health limits	20% coinsurance; 30 visit maximum
Hospice for Terminally Ill	Full coverage	20% coinsurance	100% coverage for home hospice; \$250 per admission for inpatient hospice with 5 consecutive day limit	Not specified

7. In 2001, inpatient and outpatient MH/SA limitations and higher cost sharing are phased out.

CHART 4(cont.)

BENEFITS	LOW COST SHARING (HMO) / IN-NETWORK COMBINATION PLAN	HIGH COST SHARING (FFS) / OUT-OF-NETWORK COMBINATION PLAN	BLUE CROSS STANDARD, FEHBP	FORTUNE 500
Home Health (HH)/ Extended Care (ECF - SNF and Rehab Hospitals)	Full coverage as inpatient alternative after acute illness or injury; 60 day reassessment 100 day annual limit extended care facilities	20% coinsurance as inpatient alternative after acute illness or injury 100 day annual limit extended care facilities	25% coinsurance 25 visit limit for home nursing care	20% coinsurance
Vision Care, Eyeglasses	\$10 per exam, no additional copay for glasses Glasses limited to children only	20% coinsurance Glasses limited to children only	Not covered	Not specified
Dental Prevention and Treatment for Children Emergency Dental for Adults and Children ⁸	 \$10 / visit	 20% coinsurance, \$50 deductible for treatment	Covered at fee schedule	Not specified
Prenatal Care	Full Coverage	Full Coverage	25% coinsurance	20% coinsurance
Outpatient Rehabilitation	\$10 copay per visit; reassessed at 60 days for continuing improvement	20% coinsurance; reassessed at 60 days for continuing improvement	25% coinsurance 25 visit limit	Not specified
Home Medical Equipment	Full coverage	20% coinsurance	25% coinsurance	Not specified

8. In 2001, adult prevention and treatment, and orthodontia for severe malocclusion in children are added

Cap on Small Firm Payments

Percent of Payroll

Firm Size

Average wage in thousands	Less than 25	25-50	50-75
Less than \$12	3.5 %	4.4 %	5.3 %
\$12-15	4.4	5.3	6.2
\$15-18	5.3	6.2	7.1
\$18-21	6.2	7.1	7.9
\$21-24	7.1	7.9	7.9
More than \$24	7.9	7.9	7.9

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CHART 5 (cont.)

Discounts for Individuals

Premium discounts

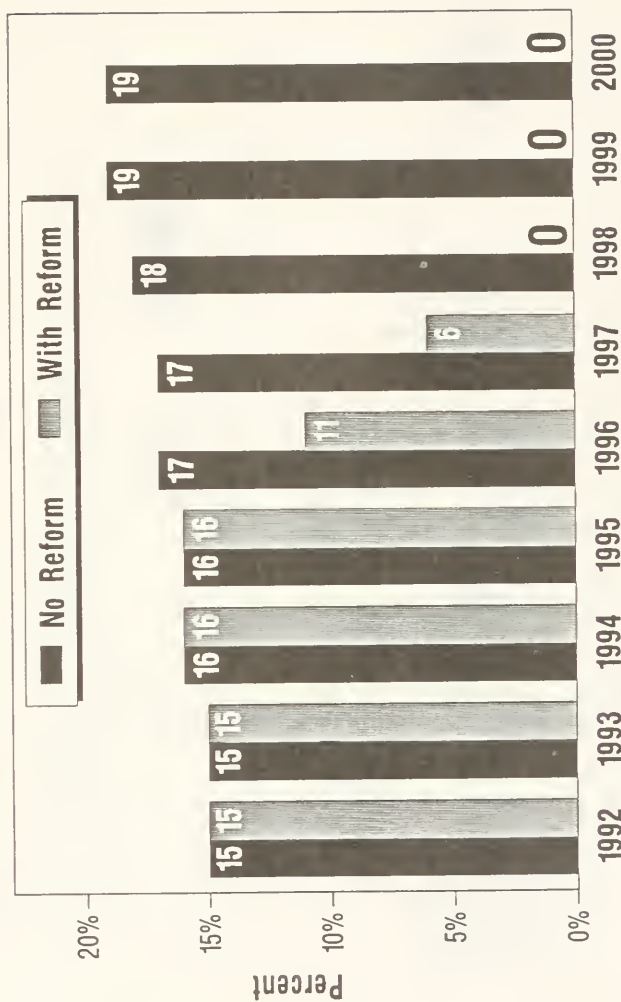
	Full-time Employees	Self-Employed	Unemployed	Early Retirees
80% Employer Share	Does not apply.	Contribution is capped as a percentage of self-employed income. • The caps are the same as those applied to small businesses.	Discounts available for individuals whose family income is below 250% of poverty. • Only non-wage earnings count as income; unemployment benefits do not. • The first \$1000 of earnings is not counted.	Federal government pays the 80% share for non-working early retirees.
20% Individual Share	Individuals and families with incomes below 150% of poverty are eligible for discounts. • These discounts are on a sliding scale, based on income. • The first \$1000 of income is not counted. For families with total incomes below \$40,000, the family share is capped at 3.9% of income.			

Cost-sharing discounts

For individuals receiving cash assistance and enrolled in a low cost-sharing plan, cost-sharing responsibilities are discounted by 80%.

Percentage of Americans Uninsured

By Year, 1992-2000



Source: HHS/ASPE projections

AAAPR256

How You Get Coverage: The New System

Health care reform brings people closer to their doctors and the high quality, affordable care they deserve.

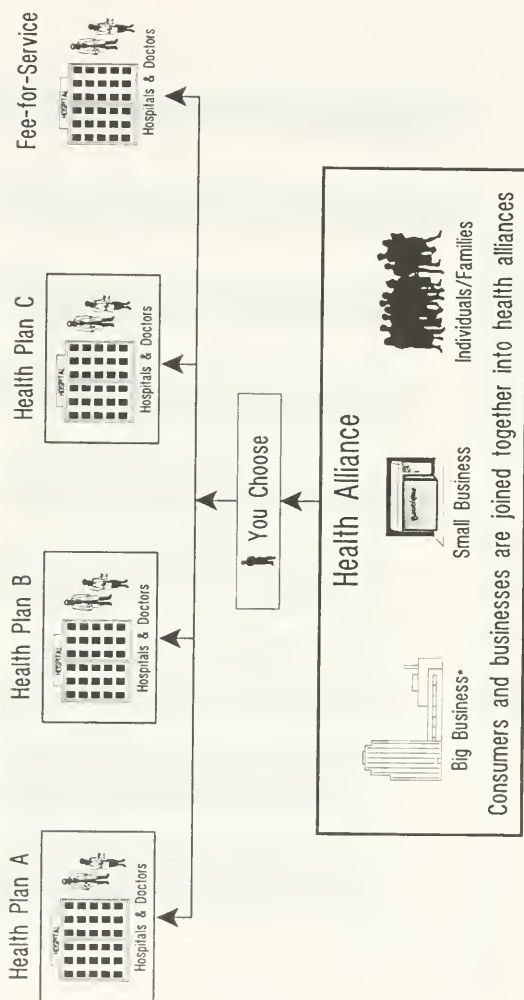


CHART 7

* Large businesses with 5000 or more employees may form their own corporate alliances.

Federal, State, and Alliance Responsibilities

The Federal Government

Sets the basic system framework

- Federally guaranteed benefits package
- Determines premium caps, increases, and enforcement
- Insurance reform

The States

Within federal framework, adopt health reform arrangement of choice

- Establish alliances
- Certify health plans
- Monitor quality of and access to care
- Implement insurance and malpractice reform

Alliances

Serve as collective purchasing agents for employers and consumers at the local level

- Solicit competitive bids from health plans
- Disseminate consumer information materials
- Enroll all eligible residents
- Collect premiums and pay health plans
- Administer employer and family discounts

Chairman SABO. Thank you very much.

Let me get back to the question of cost control because that clearly is key for numbers staying in place in outyears. I assume you take a photo of where you think the country is today and make assumptions for that for the future. Now, am I right that your limit on health insurance increases is roughly CPI plus population?

Dr. FEDER. We actually phase down to that, Mr. Chairman. It phases down, beginning when the constraints go into effect, and it hits CPI plus population in 19—

Dr. THORPE. Nineteen ninety-nine.

Dr. FEDER. Nineteen ninety-nine. Our concern is to change the way in which our health care system is operating today. We talked earlier about entitlements. You might say today that the entitlement the health care system now has is on our wallets. We clearly need to make a change in that regard.

The constraints we have assumed expect that, by changing the health care marketplace, we can have a dramatic impact on the rate of health care cost growth in the immediate term and that we need to do that in order to achieve the fiscal stability that I talked about in my opening remarks.

We have also, though, looked at the longer term beyond the year 2000 and feel that once the incentives in the system have changed, that we may want to look again at the rate of growth in our system. We may be, like other nations, able to keep our expenditures in line with the growth in our overall economy. And our proposal allows for greater flexibility once we have changed the system.

Chairman SABO. How are your reductions in Medicare reimbursements tied to your assumptions about the general cost control of general health care?

Dr. FEDER. Well, we have looked to achieve a slowdown in the rate of increase in Medicare growth that is comparable to the slowdown we are achieving in the private sector. I think it is really important in that regard to contrast the President's plan from the last decade of reductions in Medicare spending where essentially we pursued some of those reductions without any changes in the private sector and so proceeded to shift costs to the private sector. To continue in that vein could ultimately threaten access for Medicare beneficiaries. We find that an unacceptable route for the future, and, consequently, pursue them in tandem.

Chairman SABO. How quickly do you bring down that cost escalation and insurance premiums to CPI plus population?

Dr. FEDER. The phase-in that we described is from 1996 through 1999. Is that correct, Ken? Yes.

Chairman SABO. What is it year by year? Do you have those numbers?

Dr. THORPE. It starts out at CPI which we are using in our numbers to be—again, these are the estimates from the Council of Economic Advisors of 3.5 percent, which you will see CBO is at 3.1. So we have used some higher inflation numbers. 1996 it goes from CPI plus population, plus 1.5 percent, and then it slowly phases down to 1 percent, $\frac{1}{2}$ percent, and then CPI plus population growth in the year 1999.

Just as a very quick follow-on, two issues here. We felt that since we are making a substantial investment in new spending during

this time period that the actual rate of increase in health care spending is, of course, going to be higher than CPI plus population growth because we are covering the uninsured. We are providing a new Medicare drug benefit as well. So to be clear, those rates of increase are really for health insurance premiums, once everybody has received coverage.

So that is not a limit on year-to-year growth from today's baseline. That is to say, that everybody has a health insurance premium—so there is a lot of new spending that goes in up to that point. Once people do have the new health insurance coverage, the year-to-year growth in those premiums would rise at that rate.

We have also talked separately about the rate of increase in the 21st century, which we think in terms of a long-term rate of growth, that once we have achieved what we think are substantial savings that we can get in the system today in terms of administrative costs and so on, the long-term growth really should reflect not only the growth in inflation and in population growth, but would also incorporate estimates of changes in aging as well as changes in productivity. We have had several discussions with a number of economists across the country on what that long-term projected rate of growth should be, and we continue to work with them on developing a more precise formula for looking at growth in the 21st century.

Chairman SABO. We would be interested in those projections as you develop them.

Would you speak to the issue of cost variations among States, or regions within the State, and how you deal with it? Because those variations are substantial, and I would expect substantial variations from your average national premium.

Dr. FEDER. There are substantial variations, and although many of them have to do with differences in the cost of living or the demographics, they also have to do with differences in the nature of the health care systems and in the patterns of practice in those areas. As we move forward with health reform and really change the system to give health providers of all kinds incentives to operate more efficiently, we expect to see a diminution of the variations across States as we learn to do things more efficiently and effectively.

But you have expressed concern, as we have talked privately about concerns, about their being—all areas of the country being held to a rate of growth that is the same in terms of our safety net system, our fallback premium cap. No, sorry—

Chairman SABO. No, my concern is not the rate of growth. I don't want to escalate the growth for folks who have done a good job. But, as I understand the system, we build in several subsidies to firms who are located in high-cost States. While it is a small employer cap, the impact of the 7.9 premium cap which then the government cost-shares, clearly will be of substantial benefit to employers in certain States and significantly less so in other States. And, in effect, States who have done a good job are being asked to help pay for high-cost States or high-cost regions.

Dr. THORPE. The discounts for employers are 7.9 percent of the firm's total payroll. So to the extent that there is a correlation be-

tween payroll and region of the country, I believe that that would be correct.

My second statement is that, by design, we are directing these discounts to smaller, low-wage firms to make sure that as they come into the system, that the coverage is affordable. So it is 7.9 percent of payroll; it is not a premium-based calculation. It is based on payroll.

Chairman SABO. That doesn't answer my question, but think about it.

Mr. Kasich?

Mr. KASICH. I just have this one question. I need to go back to the chart. I don't know what we do without charts any more.

You know, these, again, are these projections, and this is why this is not a partisan deal. This is really the fact that there has been nobody—1967, I was barely born then. We have a whole stream of Republicans and Democrats just like you folks, and you know what? You are working like the dickens, and you deserve all the credit in the world for cranking out stuff—I mean, I can just imagine what you have been doing down there trying to crunch all these numbers out.

But no human being, it is pretty obvious, over the last, you know, 34 years, has been able to project anything right on this—in this area of what the government is going to do and what the ultimate result is. I mean, I think that is pretty devastating and really is—it is not directed at you folks. It is directed at the fact that you can do it probably much better than they can do it.

The thing that bothers me, and this is what it comes down to, it comes down to whether we are going to level with people about the plan. What I hear you saying is we are not promising to slow this growth in spending. You see, what troubles me is we wanted to have this health care reform because we wanted to slow the growth in health care spending, but the problem is is that the health care spending goes up faster if we do what you want as opposed to nothing.

These are your numbers. These aren't my numbers. These are your numbers. And I think Dr. Thorpe said that we expect things to get better after the year 2000. That is fine. What we are now telling people is that the situation is going to worsen when we come to total health care spending by the Federal Government, but it will get better after the year 2000.

Secondly, though, and this is what is equally troubling, President Clinton said in his State of the Union speech and everywhere he goes that we have to do health care reform because we have to fix the deficit. These are your numbers, okay? Minus the \$71 billion, because we don't think you are going to get credit for \$71 billion. If I wrote it in my budget, I can promise you we couldn't count it, because we couldn't get credit for \$71 billion.

But your deficit, your deficit widens. I mean, this is where you said that the deficit was going to go. I didn't say it. You said it. And this is where it is going. I mean, the only question is is that how is this plan going to fix our budget deficit, our economy and prepare us for the 21st century, out of the blueprint you got here, vision for change, if, in fact, we are spending more on health care

and the deficits are getting wider? I mean now—and creating more—yes, and to say that we got everybody—

Leon Panetta, great American. I love Leon. I do. He is a great guy. Leon is like, you know, bashing himself every day about these entitlement programs, and you want to create three more. I mean, I don't understand this. How can we create three more entitlement programs, have higher health care spending and wider deficits and you say this is a great plan? Where? Who is this great for?

Dr. FEDER. Okay.

Mr. KASICH. Yes.

Dr. THORPE. Why don't we go back through the charts.

Mr. KASICH. Good.

Dr. FEDER. I want to start with this one. I think that when we look at the Medicare program essentially and the rate of increase we have experienced, alongside, probably equally great, increases in the private sector, what we are dealing with is if problem that brings us here today, and that is a health system that is out of control, that is accountable, essentially, to no one. It is not just a public problem. It is a private problem as well, and in many periods a bigger problem in the private sector than in the public sector.

Essentially, what the Medicare system did when we put it into place was simply pay the prices, whatever were charged or whatever was spent in the health care system. It was open-ended in the truest sense.

And the critical issue we must address in health reform is holding that health care system accountable. Now, as I said at the outset, that means bringing everybody in. You leave people out, you leave benefits out, you leave people unprotected, and what you have is people with inadequate care and holes in the system that continues cost shifts. So with a comprehensive system you make a major step to holding the system accountable. You must also change that system.

And our plan, as you know, makes major changes in the marketplace and holds the system accountable, holds health plans accountable for providing a guaranteed package within premium bids.

I will stop. We have more to say, but I know Ken wants to talk about the improvements in estimating.

Mr. KASICH. Let me just say those are very good points. The only problem is that this is a projection. This demonstrates government's inability to project. It is not illustrative of health care growth. It shows that bureaucrats can't predict.

And, secondly, you just said that we have to stop cost shifting. Of course we do. But everyone knows that it is not cost shifting from the private sector to Medicare, it is cost shifting from Medicare to the private sector. So it is just the reverse of what you said.

Dr. THORPE. Let me do a slightly different tack on this, and let me talk about this in two respects. First, let's talk about the estimating issue, and, second, let's talk about why the rate of increase in spending will not and cannot grow faster than we predict. But let's go to the estimating issue first.

Go to the state of the world of government, as you call it, bureaucrats and actuaries in the early 1960's. This is a state of the world with respect to understanding how people behave who are largely

uninsured. They become insured, and it may have one or two minor articles in an academic journal. We fundamentally understood very little at that time period about what happens when you provide insurance to an uninsured individual.

So if you go back and look at the original projections, they were quite off.

Let me simply say that, starting after that experience with both, not just Medicare but Medicaid as well, that the Federal Government, recognizing this, initiated the first of several massive experimental programs and studies to precisely understand. The first one was the Rand Corporation, called the Health Insurance Experiment, which examined how people react in terms of their spending patterns, their utilization, their year-to-year growth, when they move from being uninsured to insured.

We literally have compendia of studies now that understand by income, race, region of the country, age, health status, how much people spend at a point in time as well as over time as they move from being uninsured to insured. The numbers in terms of those projections, I don't care who is doing it now, if you look at the Rand results, if you look at experimental program results, the last two decades of our understanding of how to make these projections is apples and oranges from where you are starting in 1960.

We know, first of all, how to make the projections largely because we learned from exactly this set of circumstances. That is my first point.

The second point has to do with the structure of how we have cost containment set up in this program. And there are really two critical pieces on this. One is that we know the costs of taking somebody who is uninsured, making them insured. We know the change in private spending, we know the change in Federal spending, would have added a 150 percent cushion. We know that.

Second is that the year-to-year growth in that has two pieces that we know—you never know anything with certainty, but I think with a high degree of accuracy, why the rate of increase is going to be within our budgeted projections.

One is that we believe that competition, as we have structured this with the health alliances and the health plans, will work. We have looked at experiments throughout the country in competitive bidding, whether it is the program in California, CALPERS, State employee programs in Minnesota, MRMIBS, there is a variety of published academic empirical research that shows what happens in these competitive bidding programs.

But, second, if for some reason the rate of increase in the average premiums rises slightly higher than what we projected, we have an automatic, indisputable mechanism to adjust the premiums downward and to reduce the payments. That is, an automatic adjustment occurs.

Mr. KASICH. Of course, this is precisely what Danforth said. Let me say to you your administration is \$50 billion off your budget estimates, and we are not even—we are 1 year through your term, and you are already \$50 billion off on your budgets. This was the most honest budget estimates ever devised by man. Now, if you are \$50 billion off your budgets already, you are asking me to have faith in you?

I think you are good, and I think you are smart, and I think you are trying hard, but I think Cap Weinberger, when he was Secretary of HEW did the same thing. But, of course, then have you the caps, and, as Danforth said, and I know Dr. Feder said, well, then the government will come to the rescue. Well, I mean we are back to the fact that you don't have control. But let's—you want to keep looking at charts. Let's look at a couple more charts.

Dr. FEDER. Let's look at the one you have up there now because you just raised that.

Mr. KASICH. Sure, sure.

Dr. FEDER. Essentially, we are talking about—Ken went through the cost containment system that we have. And what you are alluding to, I believe, are the caps on the entitlements, on the discount pool that is available for low-income people—

Mr. KASICH. No, no, no, I am talking about the caps you have on everything.

Dr. FEDER. All right. So am I. Excuse me. I am seeing your entire list, I am going down it. What we have done, by saying that the subsidy pool is limited, is essentially hold the system accountable. Now, Ken has been through why it is that we believe firmly that those caps will not be hit. But we, too—the President is quite concerned about open-ended entitlements and believes—do you want me to continue?

Mr. KASICH. I hear you.

Dr. FEDER. Okay. Essentially, that he feels very strongly that we have a mechanism that holds the executive branch and the Congress accountable for the efficient operation of the system, and that is the mechanism that we have put into place.

Mr. KASICH. You do have a cap, and that is why the hospital insurance people are worried about the fact that we are going to run out of money, and they are not going to have any choice.

Dr. FEDER. The insurance people I think are worried about truly changing the system, so I disagree with you about that.

Mr. KASICH. What they are worried about is if you have a cap on everything and you keep providing more benefits, you got the benefits and you don't have the money—guess what happens when you are passing benefits out but you don't have the money to pay for it?

Dr. FEDER. We see it very differently. May I respond to that or not?

Mr. KASICH. Sure.

Dr. FEDER. Essentially, the problem right now is not the scope of the benefits. The problem is how we are paying for health care. Essentially, we have got to hold health plans accountable for the package—for providing those benefits efficiently. When you look at the package of benefits we now have, it is a legitimate, reasonable expenditure or set of benefits that actually provide people the security they need.

What is wrong right now is that in an unfettered insurance market the insurance companies are able to hike the premiums whenever anybody gets sick. They are not held accountable for working with doctors and hospitals to find ways to deliver health care appropriately. They are focusing on avoiding risk, not on delivering health care efficiently.

We changed that. We can afford, as every other Nation can, to deliver health care that people expect.

Mr. KASICH. I don't disagree with that. Let me just tell you that our plan, the Republican plan—see, I think the difference is—and I don't want to take everybody's time here—but the difference is that it depends on whether you want to have a lot of government and a little bit of free market or a lot of free market and a little bit of government.

You have opted for a lot of government and a little bit of free market, but we have opted for some government. And the government we have opted for kicks the insurance companies in the backside and says you are going to have limits on what you do for people with preexisting conditions. You are going to insure them.

We would agree with you that there are appropriate places to use government, but dumping everybody into these alliances, creating all of these new entitlement programs, we may be able to reach in middle ground—and I am glad Jim Cooper is here because he has got a great way to try to move us towards the middle ground.

Let me just conclude by saying, Doctor, I respect your commitment to this, and I tell you, since 1989 I have been yelling about it, and I think George Bush came with a plan too little, too late, in an election year, didn't have any credibility. I just want to get the thing solved. And as we go through all of the numbers, this is a healthy debate. We will reach in conclusion, some middle ground, because everybody knows we have to do something about health care because everybody is going to be in the Catch-22 in the future if we don't.

Thank you, Mr. Chairman.

Dr. FEDER. Absolutely.

Dr. THORPE. Just for the record, I would be happy to provide you our estimates of the next couple of charts. (Reference is to Chart 2, Sources and Uses of Funds.)

Mr. KASICH. Yes.

Mr. PRICE [presiding]. I am taking over the gavel for a moment. It is also my turn to pose a question so I would like to focus on the question of cost controls.

I think we all know that if we do nothing, this health care system is going to eat us alive financially. The question is, how can we—in doing something, in reforming the system, how can we be assured that in expanding access we are not also going to face impossible financial pressures?

A lot of this comes down to a debate on what are the mechanisms for cost control and how well are they going to work? As I understand your plan, the main mechanism is managed competition. The main mechanism is to form these health alliances that will spread the risk and will give increased purchasing power to individuals and small businesses and that of competing health plans will bargain with these alliances and bring those costs down further. The main mechanism is competition.

But you do have a backup system of caps. You do not anticipate, as I understand it, micromanaged price controls on services or on drugs or on anything else. But you do put in place various kinds of caps. A global budget limit that will be parceled out to the alliances, limits on premium increases and caps on overall Federal

support. As you know, a lot of the debate has focused on these caps.

Now, it seems to me that debate betrays a certain anxiety, and the anxiety is not just on your part, the anxiety is on the part also of the proponents of so-called pure managed competition, a certain anxiety that maybe this competition isn't going to work. Otherwise, why are we so anxious about the caps? Why are you so eager to put the caps in place and why are the proponents of pure managed competition so spooked by the caps? There seems to be a lot of anxiety about how well-managed competition really is going to work in bringing these costs down.

So that is what I want to ask you. What makes you think the caps are necessary? How likely is it that the caps in the end will have to be invoked? Can we rely on increased competition among health care plans to bring the costs down as projected? Why don't you feel safe in relying solely on that?

And then, finally, how do these budget cap proposals differ from the kinds of cost controls that you find in other plans such as the single-payer plan which, as I understand, would require a great deal more micromanagement? And why did you choose your approach? But, first of all, why this cap mechanism and how realistic do you think the projections for cost control through competition are going to be?

Dr. FEDER. All right. Well, I think you put it very well, Mr. Price, when you talk about anxiety in this system, and I think that what we want to do is put some of that anxiety to rest.

First, just before I turn to the question that you want me to focus on. In your initial statement you talked about a concern about what expanding access would do to health care costs. I want to remind all of us that essentially, when it comes to people without insurance coverage today, we are already paying many of their bills. So those are already in the system. What we are doing is developing a fairer and better system of paying for that health care.

The second thing to remember is that we are creating a system in which we are gaining the revenues to pay for that care by having those who are now without insurance participate in the financing. Remember that 85 percent of the people without insurance coverage are connected to the work force and that they and their employers will be contributing to the financing. So I just wanted to establish that as a backdrop.

Now, your real question is, what are our expectations about competition? As Ken indicated earlier, we believe very strongly that competition in parts of the country that sustain it can have a dramatic impact on slowing the rate of increasing health care costs.

Once we give everybody a guaranteed package so that all plans are offering the same package, we give people incentives and the capacity to choose among health care plans, knowing that if they are provided with information they have an incentive to choose a plan that provides them value for their dollar. And once we hold health plans accountable for delivering that package within their premium bid, we believe that the patterns of cost increases in the current system will be changed dramatically.

But we are talking about something that is, based on evidence from various parts of the country. We have not had that system in

place throughout the country. We have had limited but not extensive experience. And if we are going to require everybody to participate in this system, as we believe we must, we have got to guarantee them the predictability of their obligations.

It is for that reason that we feel that we need to have this backstop mechanism so that everyone's anxiety can be alleviated to know that there really is a backstop that guarantees that affordability.

You asked how the premium caps differ from the cost containment mechanisms in a single-payer plan, and you rightly said that we are not proponents of micromanagement of the health care system. A single-payer system relies on a government-determined payment mechanism for providers in which government sets all of the prices. We have some experience with that kind of system in the Medicare program. It has in some cases been somewhat successful, but there are concerns, one, when we try to set all the prices about our ability to do it, and, two, that in addressing only prices, what we don't address are the use of services and the volume of services provided so that we set up no system in which providers really have an interest or stake in delivering services truly efficiently. We need to change that.

And underlying our reforms are the critical changes in the system that hold health plans involving all of the providers accountable for delivering services based on a premium bid which takes into account both prices and volume and lets plans and their doctors and hospitals work out the terms of payments and the management of efficient quality service themselves. So we would distinguish ourselves in that way.

Mr. PRICE. What do you say to critics who suggest that it all amounts to the same thing? It all amounts to governmental price controls with all of the distorting effects that that has had on markets in the past? How do you defend—in other words, the accusation is that this is really price controls once removed, and the effect of these caps is really going to be indistinguishable in the end from that kind of micromanagement?

Dr. FEDER. Well, I would first tell them they are wrong and then tell them how they are wrong. Essentially, as Ken indicated, we have spent extensive time and energy estimating what premiums are likely to be. They are premiums based in part on—in large part on today's system, although allowing for changes, some administrative savings and some other savings. So we are taking the current system into account and then essentially allowing the system to work.

Our cost containment relies on bids from health plans. It is a ground-up approach based on truly making the market work, allowing the competition to work both in terms of the health plan's participation in the system and in making a marketplace. That is the role of our health alliances. So what we think is we are truly enabling a market to operate in the health care system rather than building a regulatory system.

Mr. PRICE. Let me ask one final question about an apparent exception to this in your plan. You may want to answer briefly and then submit a fuller answer for the record, because I know we do need to move along.

Let me ask you, though, about the cost of prescription drugs. Now, presumably, the cost of prescription drugs in this plan would not be micromanaged, as you say.

Dr. FEDER. That is correct.

Mr. PRICE. They would rely on the overall caps and the competitive pressures to bring down the cost of drugs to the alliances and to the health plans. There do appear to be a couple of instances, however, where you envision a more direct regulatory intervention in terms of the pricing of drugs. First, you propose to empower the HHS Secretary to impose a manufacturers' rebate or to exclude a drug from Medicare coverage if she regards the price as excessive. And, secondly, you authorize a new HHS committee to examine the prices of what you call new breakthrough drugs.

Now, to concentrate on the latter, how would this work? How would this committee work? Why is it necessary? Could it potentially have a chilling effect on research or on the development of breakthrough drugs? As I said, this appears to be an exception to your general pattern of relying on competitive pressures.

Dr. FEDER. Well, let me emphasize that that committee is essentially an informational committee. It is not a regulatory committee, and there is not regulatory power associated with the breakthrough drug committee or commission. Its job is essentially to provide information on the cost of breakthrough drugs, essentially to inform the private system on which we are relying for health care to control our rate of increase in health care costs. So we would not see it as a departure in that regard.

With respect to the Medicare program, although we are moving ultimately toward a single system in which all Americans will be in the same kinds of health care delivery systems, the Medicare system remains distinct at the outset. It is then, therefore, appropriate as Medicare covers prescription drugs that it have a pricing mechanism, and we have developed that mechanism and its rebates in line with recognizing that the market for prescription drugs is greatly expanded by the—will be by the enactment of universal coverage, and that as a large purchaser in that marketplace, though still a minority purchaser, that the Medicare program is entitled to those discounts.

Mr. PRICE. But on that breakthrough committee and the informational role that it would play, surely you would expect that to have some effect on the alliances and on the purchasers of drugs.

Dr. FEDER. Well, absolutely. And I think the issue here is that as purchasers, purchasers need information, and that enables purchasers in a private marketplace to deal effectively with those from the—the suppliers. And it is to provide them that information that the breakthrough committee would be created.

Mr. PRICE. All right. Thank you.

Mr. McMillan?

Mr. McMILLAN. Thank you, Mr. Chairman.

Let me express my thanks to both of you. I issued a plea for candor in getting the benefit of your analysis up front in financial terms last week after hearing from Secretary Bentsen and you, Dr. Feder, and others, and I think you have responded to that, and I appreciate that.

The chart that we have here today, while we may disagree over policy implications and assumptions therein, certainly lays it out, and I want to spend more time examining this.

But I do appreciate you doing that because, regardless of whether we are talking about the administration's proposal or any of the alternatives, we need to get up-front with the financial analysis because, in part, that is where the elevation of the problem began.

I am going to subject you to one more chart, which I brought in here, not knowing what others would do.

CBO Baseline Projections For Medicare & Medicaid

(by fiscal year in \$billions)

Medicaid

	1992	1993	1994	1995	1996	Totals
Jan. 1991*	\$57	\$64	\$72	\$80	\$90	\$363 billion
Jan. 1993**	\$68	\$80	\$92	\$105	\$118	\$463 billion

Difference,

1993-1991	+11	+16	+20	+25	+28	\$100 billion
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\$100 billion added to Medicaid CBO baseline between Jan. 1991 & Jan. 1993 Budget Outlooks due to "technical corrections." Technical adjustments not subject to PAYGO requirements.

Medicare

	1992	1993	1994	1995	1996	Totals
Jan. 1991*	\$127	\$140	\$156	\$173	\$194	\$790 billion
Jan. 1993**	\$129	\$146	\$167	\$188	\$211	\$841 billion

Difference,

1993-1991	+2	+6	+11	+15	+17	\$51 billion
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\$51 billion added to Medicare CBO baseline between Jan. 1991 & Jan. 1993 Budget Outlooks due to "technical corrections." Technical adjustments not subject to PAYGO requirements.

* *The Economic and Budget Outlook: Fiscal Years 1992-1996*, January 1991, Congressional Budget Office, p. 91

** *The Economic and Budget Outlook: Fiscal Years 1994-1998*, January 1993, Congressional Budget Office, p. 49

And if you can see this—this basically is two of the more recent CBO projections on Medicare and Medicaid made 24 months apart, one in January of 1991 and another in January of 1993. The same basic programs being projected, 24 months apart.

I put this out there to illustrate how out of control those two programs are. To boil it all down between the two of them, the projections 24 months apart over a 5-year period were \$150 billion apart, and I suppose if we added your projections here it would cover, I guess you cover 5 years as well, is that correct?

Dr. THORPE. Yes.

Mr. McMILLAN. Anyway, it shows you that, given the nature of the way we have been doing business, just how far off we can be. Those are reflective of a lot of different things.

Now, I would like to bring that back to really the first point and that has to do with some of the things that we were discussing with respect to Medicare savings and Medicaid savings. I think what you are proposing, including caps and managed competition and so forth, could well lead to an enhanced element of control over what we would classify today as Medicaid cost, plus all of the additional subsidies that you will add to the program. And, frankly, I don't argue about adding the additional subsidies. I would go about it in a different way.

But I do think that the system that you put together will not encourage competition. It will discourage competition. It will consolidate purchasing, forcing the government to be the final arbiter, so that the caps will be far more important in that component than what you might envision. Frankly, I think caps might be needed anyway, regardless of what system we have, so I am not going to argue that point so much.

But, under Medicare, which is \$100 billion and \$150 billion in this 24-month projection, it seems, if I read your figures right, that most of your savings are going to be derived by altering the revenue side of Medicare. Changes in premiums, perhaps we need more details on this, that individuals would pay perhaps some adjustment in co-payments. But I don't see much there on the cost control side.

You mentioned, Dr. Feder, that ultimately Medicare might fold into the total system. But starting at the outset we would, it seems to me, essentially be faced with the same out-of-control cost pressures that exist in Medicare today, a whole host of them. And I am not going to try to elaborate on them, but they clearly include excessive administrative costs. They include excessive terminal health and misapplied terminal health care costs, defensive procedures and a whole host of things.

Would you care to address the issue of your capacity to control cost in Medicare under what you are proposing?

Dr. THORPE. I would just like to spend 10 seconds on that chart and then we will go right to this question because I think that Congressman Kasich also raised the issue. I would just make three points again on this.

I have already made one about our capability to make estimates of the costs of providing insurance to people who were previously uninsured. The state of the art is radically different than it was in 1960.

Second, the structural components of the program would allow us to stay within the projected rate of increase that we have talked about.

The third point, which is related to this. Let me give you a sense of how changes in economic assumptions will affect what I have called our net subsidies, which really is the issue. Suppose that there is a change in economic assumptions. How would that affect our net subsidies?

What happens is the following: We have done obviously several projections, but we changed and updated our economic projections to use the most recent inflation projections we could find, which are the highest 3.5 percent. We had been using, based on last winter's CBO projected inflation numbers prior to this, 2.7 percent. As it turns out, in terms of the net effect on our discounts, this works in offsetting ways.

On the one hand, the costs of the discounts rise. On the other hand, the savings that we achieve rise as well when we move from inflation of 2.7 to 3.5 percent.

When you look at our 5-year subsidies, our 5-year discount totals, when we had a 2.7 percent inflation versus our 3.5 percent inflation assumption—and look at it over exactly the same time period, the difference in our net subsidies over a 5-year period was under 2 or 3 percent.

We had something like \$161 billion in this program. We had estimated earlier like \$164 billion or \$163.8 billion, I can't remember exactly, but it was within \$5 billion. And the reason is that the way that the savings that are most important here work is due to changes in the economic assumptions as we have developed it, in contrast to this, which is simply an increase in cost due to technical corrections, and these factors work in countervailing ways.

Mr. McMILLAN. Well, I think that is part of the answer. But another part of the problem here is a lack of precision in the definition of the benefits under the program. And I think under what you are proposing, both in your modification for Medicaid and in your subsidized or discounted program, you are going to be very precise in defining the standard level of benefits, and I think that is good. I don't care what comes out of here, whether it is a Republican proposal, or whoever's plan, it has to be very precise in defining what standard benefits are. I think that is, as far as your proposal is concerned, then gives you a lot more certainty in terms of making projections.

On the other hand, we are not getting precise, I don't think, in defining what the level of benefits are under Medicare.

Dr. FEDER. Congressman, I think that the issue—I appreciate your sharing our views, essentially, on the effectiveness with which we are addressing the private sector and the younger population.

Mr. McMILLAN. I just said in the definition of benefits.

Dr. FEDER. I am sorry. I didn't mean to overstate. I think that I take my support where I get it.

The question that you are raising, though, I think is not so much the definition of benefits. I think it is the operation of the health care system and the way we are purchasing health care. Medicare, the Medicare system is a fee-for-service system, primarily, although we are making many changes to allow Medicare beneficiaries a

choice of health plans that we believe will be able to manage health care effectively. That is not a change that can occur immediately, nor is it a change that is likely to get scored, and, for that reason, we need some specific changes in Medicare policies in order to achieve the slowdown that we have put forward.

And you rightly noted there are some changes on the revenue side, but there are also changes on the payment side. They are listed in the legislative language, and we would be happy to provide you more detail on those specific proposals.

Mr. McMILLAN. Well, I will study those more carefully. I would make the argument on a rational basis and maybe on a political basis that this is not a good argument that Medicare should be folded into the entire system right at the outset because we have an opportunity here, when we are dealing with the problem comprehensively, to do that. And I understand the political difficulties of doing that.

But you are making some major trade-offs in terms of long-term care and pharmaceuticals to senior citizens that are really an enormous extension of benefits. And I think that that would be the time to fold them into the entire system, which then would enable you to perhaps exercise the same scrutiny over costs. And I say that in a constructive sense of trying to manage costs down, not just fix prices and force a top-down solution. I think you have an opportunity to do that, and I think we are missing that in the proposal here.

Dr. FEDER. I think we share your interest in moving in that direction. I think that there are issues as to speed, and, essentially, as new plans are developing and have not had experience with an older population, I think there are some issues there.

But let me also comment on the long-term care program, because it was mentioned earlier by Congressman Kasich, and I wanted to clarify its design. It is not an individual entitlement program. It is a program that essentially provides funds—it is a Federal-State program that provides funds for the expansion of home- and community-based services.

But it operates through grants to the States, rather than entitlements to individuals, and we have done that for a couple of reasons. We have done it, number one, because we don't think we are in a position to prescribe precisely what it is that individuals are entitled to in terms of a home-care benefit. In fact, there needs to be flexibility to tailor what are largely nonmedical benefits to individual circumstances and needs, and there needs to be tremendous flexibility to do that efficiently and effectively. And that is the approach that we have taken in the design of this program. So I think we have been sensitive to concerns both fiscal and operational in the design of that program.

And, finally, let me just say that the benefits in that program is not a Medicare—

Chairman SABO. We are trying to get the mikes fixed.

Dr. FEDER. Essentially, the benefits are for people of all ages with disabilities, and so that is not a part of the Medicare program. That needs to be understood as well.

Mr. McMILLAN. I think I am out of time. I hope I may have the privilege of making a direct request for additional information with respect to this. I thank you again for your testimony.

Thank you.

Chairman SABO. Mr. Pomeroy?

Mr. POMEROY. I want to echo my congratulations to each of you for the important part you have played in this vital undertaking, attempting to contain costs and fix the tough problems that presently plague our health care delivery and financing system.

There are some assumptions in your program that I have not been able to understand: first, trying to get costs in line with CPI by the turn of the century or 1999. How can you accomplish that objective, knowing as we do that the older people get the more they utilize medical services and, therefore, the more they impact costs?

Secondly, the advent of medical technology adds to costs, does not reduce costs. We can expect some wonderful advances in medical technology between now and the end of the decade. In light of these two forces which push costs up, how do you bring costs actually down and in line with CPI?

Dr. THORPE. I think it is important for us to make sure we clearly demarcate two time periods in this: The short run that is—here I am defining as our program becomes fully implemented through the year 2000; and, in some cases, post-2000—I think the answer is a little bit different in terms of what growth is.

Let's take the near term. Remember what is going on under the proposal in the near term. We are making some substantial investments in the short run with respect to covering the uninsured; providing better benefits for the underinsured. We have our Medicare prescription drug program. Each of these will increase spending in the health care system. At the same time, we are projecting substantial savings as the system becomes implemented. Savings are achievable from reductions in administrative costs, reductions in inefficient and wasteful practice patterns, bringing into the plan cost-conscious choice of health care by individuals, both with respect to how plans are organized and with respect to how individuals make the choice of health plans.

All those are going on simultaneously. All the plan, as I mentioned before, says is that once people are insured, that the growth in their premiums would over time rise at CPI plus the schedule that I laid out, 1.5, 1, .5, and so on.

We recognize that between 1995 and the year 2000, the actual growth in health care spending will not keep pace with population growth. It will be higher than that because there is new money coming into the system. So, for example, the actual growth between 1995 and the year 2000 is likely to be something that could be 6, 7 percent—we can quote you the precise figures, that is just an illustration.

So the actual spending in the system is not CPI plus population growth because we are making new investments.

Pertinent to the chart Congressman Kasich showed on credible spending, it is clear as we implement the program, the national health expenditures for a short period of time—we think maybe 2, at most 3 years—will slightly increase; that is, Federal household/

business spending in the aggregate will increase slightly because we are making new investments and phasing in the program.

Past 1999, national health expenditures, given the cost containment program we have outlined, will fall relative to the baseline. Indeed, as you can see from our projections, there will be a reduction in the deficit; and the—in the first 2 years. By 1999 and 2000, we can see the deficit reduction features of the plan really start to accumulate.

We think in the near term, that having premiums rise at CPI plus the schedule we laid out is clearly doable, because we are simultaneously getting a substantial amount of one-time savings as well as making new investments in the system.

I think the real issue is what is a long-term growth rate. I consider “long term” here being the 21st century. As a result, provisions in the plan state that the factors we think should be included are CPI, plus population growth, plus—which we have in there as real GDP, things such as aging, changes in productivity, which do relate in part to changes in medical technology.

I completely agree with you, the long-term growth rate needs to account for those factors. We have them in the legislation. We think in the short term, however, given the fact we are making a substantial investment in spending and getting savings, that the schedule we put forward is clearly achievable.

Mr. POMEROY. Do any of these other plans that are presently in existence, in your view, produce even short-term savings in medical spending?

Dr. FEDER. Yes, some of them do. I think there are savings, some of the savings in administrative costs that are included in some proposals, that are substantial, significant and share—

Mr. POMEROY. That would be the single-payer system?

Dr. FEDER. That has substantial savings in administrative costs. Yes, I think other plans would achieve savings in administration for small group insurance through greater efficiencies, as would we. I think what our plan does that is a combination of some of those mechanisms, is to achieve administrative savings and delivery reform, to a considerable extent, as a way to change the system over the long term and have everybody in it, which is the difference from some of those other proposals.

Mr. POMEROY. Thank you.

Chairman SABO. Before I recognize Mr. Miller, do you have charts that project costs, revenues, costs, deficit reduction out through, say, 2005, that you can give the committee?

Dr. THORPE. We are working on those.

Chairman SABO. That would be useful for the committee to know what assumptions are used as you project out beyond the year 2000.

[See Chart II-A on pg. 84.]

Chairman SABO. Mr. Miller?

Mr. MILLER. That was one of my first questions, the details of your sources and uses. You don't have them right in there, more details as far as explanations and how they are derived.

Dr. THORPE. We would be happy to supply them to you. This is a summary. We, obviously, have very detailed backup for line items, how it is estimated. As we mentioned, we will be making

available to the public and the staff and the committee the assumptions underlining the models, how they work, how they generate the estimates and so on. We are close to having all of those ready.

Mr. MILLER. How close?

Dr. THORPE. One thing I have learned is not to make predictions in this game. We do have what we think is very close—we have drafts of each of those. We are in the process of having them being reviewed by OMB, Treasury right now. We think we can share them with you very soon.

Mr. MILLER. We have been saying a lot of times the devil is in the details. The more I see details, the more scared I am of this whole system. I am more scared all the time because of these numbers, because of these assumptions.

Are you aware of CRS studies? Mr. Kasich said when you looked at the original projections of Medicare in the early 1960's—and I understand we did not know the ability of projecting back there, projecting into the future. Every time we make changes in the system—the dialysis changes in the early 1970's, catastrophic in the late 1980's, little changes in the Medicaid program that makes people more eligible for certain benefits, the comparison of projections to the actual costs shows that the projections never live up to the reality.

Someone was passing out catastrophic in the late 1980's, how the—that was in existence for 18 months or something. The question goes back to John Kasich's question, the credibility of projections.

Dr. FEDER. Mr. Miller, I think as we looked over changes in the health care system on the public or private side over the last several decades, what we have seen are changes that do tend to expand benefits with limited attention to changing the delivery system or promoting a system for cost containment.

We are very concerned about that, which is why cost containment, changing the health care delivery system is so fundamental to our reform. I think that is very different from the experiences you cited.

Mr. MILLER. I think you have to see what the assumptions are that have been made and see the projections. You are making projections, too. These are much more dramatic, significant than a change in a dialysis program or even the catastrophic programs.

I am interested if there are such studies that have been done by academics, those type studies? That would suffice.

I have one other question. As a businessman, I remember when we took one of my businesses and created a separate insurance fund. There were 60 employees in the fund. Basically, you self-insured at first, \$20,000, such. One of the concerns I had as a businessman is the tail effect, the 1 year—the cash flow standpoint. Say I started the plan January 1, 1994 and ended it after 12 months. From a cash flow standpoint, you put money in the system, cash flowing in, but not much going out during the first 3 months.

After you got out of the system after 12 months, another program, you have no cash inflow but cash outflow. That was a tail, we had funds for the tail, buying insurance for the tail. That is just a small situation with 60 employees.

You know, just from a cash-flow standpoint, businesses in it, that are not funded properly for that tail, if this program started, you know, national plan started, say, the first of the year, the claims, that the amount of money being paid in January for claims in 1993, I can see tremendous bankruptcies and financial problems for insurance companies, small companies, medium-sized companies that have self-insurance funds paying claims usually paid for by the current cash flow.

What kind of analysis of that type problem has been done?

Dr. FEDER. Essentially, there have been extensive analyses done of capitalization required of plans and expectations of health plans. We do not have with us today our insurance expert. We testified yesterday, with Gary Claxton, he was addressing that issue, how it was considered in the plan.

One of the pieces he mentioned or addressed is that essentially going to electronic claims processing you are dramatically reducing the risk in terms of a tail because you are speeding up the claims payment dramatically. That significantly lessens that problem.

I think you are also alluding to self-insurance, and the risks faced by the smaller and mid-sized firms that have gone to that kind of self-insurance. Concerns about that kind of arrangement is one of the reasons that we are essentially putting all but the largest firms in a pool in which they are purchasing insurance as opposed to relying on self-insurance, limiting the self-insurance approach to large firms that are able to manage their risks. So we could provide you more information on that subsequent to the hearing.

[The information follows:]

Moving from the current health care financing system to the new system envisioned under the Health Security Act will require existing payers to essentially "close the books" on their current operations. Insurers and self-funded plans will need to identify claims and expenses incurred prior to new system implementation and set aside funds to pay them when they become due. Insurers and other "funded" plans routinely establish reserves for such future liabilities. Self-funded arrangements will need to set aside additional funds, either from tapping into company funds or borrowing. These plans will essentially be repaying the savings they realized in the first few months after the unfunded arrangement was established.

Mr. MILLER. Did you say whether there are studies on the projections and how effective they have been?

Dr. FEDER. I know there are individual studies. I actually did one myself. So, I think that there are some of those; and if we—we would be happy to look at that.

Mr. MILLER. The track record is not good on projections versus reality.

Dr. FEDER. I think we have some differences of opinion as to what determines those inaccuracies and difficulties in estimating.

Mr. MILLER. Thank you, Mr. Chairman.

Chairman SABO. Ms. Woolsey?

Then will be Mr. Hobson and Mr. Cooper.

Ms. WOOLSEY. Thank you, Mr. Chairman.

I thank both of you for being here and being so patient with our questions.

I have been holding a series of town hall meetings. One thing I want you to know is there is a considerable amount of support for the single-payer system out there. At the same time, there is a lot

of public skepticism. We have a lot to do to educate our public about what this plan covers, where it is coming from, and who is going to benefit and who is going to pay. So I had both ends at two different meetings I had; one very supportive, one not at all. I have five more meetings to go in the next month. The more we know about it, the more they know about it, the better off we will be.

One of the areas that was questioned in both town hall meetings that I had concerned business and small businesses. The questions that were raised had to do with the subsidies—how they work, what percentage of the businesses we thought would be subsidized, and how many people in this country does that affect. I didn't have an exact answer for them on that.

They also wanted to know how a part-time worker plays into the formula; and there was a concern that this formula could encourage hiring lower-waged workers.

I have other questions, but do you want to respond to those two first?

Dr. THORPE. In terms of the specific distribution of where the subsidies go, as you could see from my earlier chart, three-quarters of the subsidies are tailored towards small firms, most of which are low wage. We do have data we can share with you. I would be happy to provide that to the committee, on the distribution of how many workers by firm size would receive employers' discount and how many workers would receive employee's discount. We would share that information.

[The information follows:]

Breakdown of Workers According to Subsidy Levels

Percent Distribution	In Regional Alliance							Corporate Alliance	Workers (thousands)
	Firm Cap 3-5%	4-4%	5-3%	6-2%	7-1%	7-9%	No Cap		
All Workers	5%	3%	3%	4%	4%	16%	45%	19%	116,641
By Firm Size									
Less than 25	23%	10%	9%	12%	10%	5%	31%	0%	26,989
25-99	0	9	9	9	9	17	48	0	16,345
100-499	0	0	0	0	0	44	56	0	18,025
500-999	0	0	0	0	0	38	62	0	7,145
1,000+	0	0	0	0	0	27	73	0	15,734
5,000+	0	0	0	0	0	0	31	69	32,603
By Industry									
Ag/Forestry/Fish	20%	21%	15%	8%	5%	13%	16%	3%	1,938
Mining	0	0	1	1	0	4	59	35	7,789
Construction	0	1	6	12	13	15	45	7	6,755
Man Durable Goods	0	0	1	2	3	15	46	32	12,531
Man Non Durable Goods	1	1	2	3	4	24	34	30	9,132
Trans/Comm/Public Utilities	0	1	1	2	3	9	51	32	8,547
Wholesale	0	0	1	2	4	10	65	19	4,623
Retail	15	9	5	5	2	19	14	32	19,815
FIRE	0	0	2	4	5	17	47	25	7,754
Bus/Repair	3	4	8	9	8	20	31	18	5,786
Personal Services	35	13	4	3	1	18	6	20	3,649
Ent/Recreation Services	13	13	5	3	1	16	37	12	1,911
Professional Services	4	2	3	3	3	20	62	4	27,572
Public Administration	0	0	0	0	0	0	100	0	5,657
By Coverage									
Single	7%	5%	4%	4%	4%	18%	39%	19%	39,727
Not single	4	3	3	4	3	16	47	19	77,114
By Wage Income									
<15K	11%	6%	5%	5%	4%	18%	34%	16%	41,797
15-25K	4	3	3	5	4	19	44	17	25,411
25-35K	2	2	2	3	4	15	52	20	18,974
35-45K	1	1	1	2	2	13	56	23	12,078
45-55K	1	1	1	2	3	11	54	27	7,614
>55K	1	1	2	2	2	11	56	25	9,966
By Hour Status									
Part time	12%	5%	4%	4%	3%	16%	37%	18%	13,672
Full time	4	3	3	4	4	16	46	20	102,968
By Region									
Northeast	4%	3%	3%	3%	3%	24%	42%	18%	24,097
Midwest	6	3	3	4	3	18	43	20	28,824
South	6	4	4	5	3	14	43	21	28,833
West	5	4	3	4	4	11	51	18	24,097
By Age									
<25	7%	5%	4%	3%	3%	16%	40%	22%	18,182
25-35	5	4	3	4	4	18	42	20	33,437
35-45	5	3	3	4	3	16	48	18	31,147
45-55	5	3	2	4	4	15	48	19	20,517
55+	6	4	4	4	4	17	44	17	13,508

Source: The Urban Institute

Model 106C

16-Dec-93

Distribution of Workers by Average Wage, Firm Size, and Current Offering of Health Insurance

Firm Offers Insurance

Average Pay at Firm	Firm Size Loss then 25	25-99	100-499	500-999	1,000-4,999	5,000+ In	5,000+ Out	Total
<12K	2,344	1,850	1,933	714	2,931	946	1,402	12,020
12<15K	1,111	1,074	1,363	418	1,173	466	685	6,250
15<18K	1,136	1,030	1,215	436	1,105	309	581	5,912
18<21K	1,705	1,153	1,405	559	1,491	496	810	7,819
21<24K	1,464	1,263	1,648	643	1,844	567	1,085	8,554
24<28K	1,823	1,973	2,298	948	2,776	733	1,212	11,763
28<32K	1,080	1,586	2,030	669	2,505	644	1,111	9,625
32<36K	683	1,183	1,502	628	1,823	516	1,101	7,436
36K+	1,442	1,769	3,051	1,617	8,541	2,615	5,480	24,525

Firm Does Not Offer Insurance

Average Pay at Firm	Firm Size Loss then 25	25-99	100-499	500-999	1,000-4,999	5,000+ In	5,000+ Out	Total
<12K	4,556	952	436	122	556	249	306	7,179
12<15K	1,688	379	222	47	118	49	87	2,590
15<18K	1,471	301	169	49	80	54	75	2,189
18<21K	1,832	320	157	46	116	90	99	2,660
21<24K	1,292	302	131	61	106	94	84	2,070
24<28K	1,439	489	183	72	160	77	79	2,479
28<32K	714	311	151	42	89	44	85	1,436
32<36K	398	195	82	25	67	37	67	961
36K+	820	136	160	52	202	87	211	1,720

Modal 106C

Dr. FEDER. Clearly, the Chairman is interested in those subsidies as well.

I think the key thing, Congresswoman, is that while we are expecting them to pay 80 percent of the premium, their obligations are capped, and they can look at themselves as individual businesses as to how that cap affects them, based on their size, the number of employees they have, and the level of their payroll.

So the smallest businesses with relatively few workers are capped at that 3.5 percent. That is, roughly, 15 cents an hour for employers of minimum-wage workers. We can certainly provide you the numbers.

But I know my experience in talking to the town meetings is that people are very concerned with exactly how it affects them. We should provide you the schedule so you can tell them.

Ms. WOOLSEY. That would be very helpful to have. Another question they had I heard more than once is, if an employer hires a student—a college student or a high school student—and that student is covered on their parent's insurance or by their parents' employer, does the student's employer have to pay for the student also?

Dr. FEDER. No. They continue to be on it. You asked about the part-timers. Essentially, employers contribute for part-timers based on the—on a pro-rata basis. If we think of 30 hours a week as full-time, and you have a worker who is working 15 hours, then you make half the contribution you would otherwise make. So they are part of the system, but the contribution is adjusted so that there is no particular advantage to part-timers as full-time workers.

Ms. WOOLSEY. But if the student is covered by the parent's plan, they don't—

Dr. FEDER. That is right.

Ms. WOOLSEY. That is good.

Are we going to subsidize small employers that are extremely profitable? Is there any profit test in this?

Dr. FEDER. You know, we looked. As we looked at, and are concerned about, small employers, and targeted the subsidies, as Ken indicated, there, we looked at a number of ways to do that. Profitability is very difficult to measure. We did not find a way to target them in that direction.

What is of primary importance is not increasing the labor costs associated with low-wage workers. So that is the way we targeted them, and we did not find a better way to do that.

Ms. WOOLSEY. I am sure there is concern about workers with families having a greater health insurance contribution made by the employer. Would this encourage an employer to start hiring workers without families?

Dr. FEDER. Essentially, that is—they will have that incentive today. If anything, I think we are improving that in terms of the way we are distributing the burden. So we think we are making things better, not worse.

Ms. WOOLSEY. Well, we need the public to hear all the answers and not just all the questions.

Thank you.

Chairman SABO. Mr. Hobson?

Mr. HOBSON. Thank you, Mr. Chairman.

Good to see you both again, doctors, Ken.

You may not know this, but Ken came out to a health care seminar I did a couple of years ago when he was in the private sector. At that time, he was the expert on pay-or-play. He may have gotten what he was looking for.

I appreciate, Dr. Feder, your meeting with us as you did earlier with the Republican Leader's Task Force on Health.

Let me just talk a minute about these cost estimates and the future, and whether John is right or you are right about the accuracy of the targets. I think you say you are keeping the system accurate because you are going to put in the caps and force it to conform with your numbers. I guess even if you are incorrect, you are going to push it back.

The problem is that you may push it below what the market is actually doing. If you do that, you are going to lead to questions of rationing and excluding benefits to people; and then you begin to affect the quality of care. That is one point I would like to make.

The other point comes back to what Ms. Woolsey is talking about. Are we going to subsidize Wal-Mart?

Will Wal-Mart—which makes money, which has a lot of people who are part-time, or any corporation like that—get a subsidy under this?

And third, you have a chart that talks about fee-for-services. I wonder if we are being intellectually credible when we discuss fee-for-service. Basically, if I understand how the alliance works, eventually, with your global budgeting and community-based budgeting, fee-for-service is probably gone. You may disagree with that, but I would like to talk about it.

The last item I will talk about is identifying accurate numbers on cost. I went to the Rules Committee on this, and Mr. Sabo and I had a little discussion on the floor. I think this is good what we are going through today. I want to be sure that all the numbers compare apples to apples and oranges to oranges. I think at some point I would like to talk about whether or not we really are doing that. Are we leaving out the cost of the mandates and the shift of funds in the private sector? Are we really including all the dollars in there?

With that, I will let you respond and do what you want.

Dr. THORPE. Let me start with the first issue on savings. As I mentioned, having seen the set of charts up here, we will be happy to provide that, based on our estimates of what the change in Federal spending is in the deficit, because I am not sure what underlies those, but in particular, is—as the congressman mentioned be—things such as revenue effects, which are scorable changes in the budget which were excluded from that, I think, incorrectly, will be included in our charts. I want to be sure we get that right.

Second, with respect to the savings, we do have documentation that we will be coming forward with, with specific savings on the private side in terms of changes in the system, administrative savings, changes in practice patterns that we think will happen as we move into the new system, changes in areas such as duplication of technology, and so on, year by year, where we think as the pro-

gram comes on, where the savings are on the private side as well as the public side.

As you will see, our year-by-year estimates of the private savings that we think will happen with the competitive system as we are developing true competitive bidding through negotiation between alliances and health plans, that those savings are sufficient to generate what our projected growth in spending is. So they do generate sufficient savings without the reliance on the backup mechanism in order to achieve year-to-year growth. We will be happy to share that with you. We do have them outlined in detail.

So we do have specific savings that we think are going to occur, the savings are sufficient on the competitive side to achieve the rate of growth that we outlined in the President's plan.

[See Chart III-A, pg. 97 and Chart III-D, pg. 102.]

Mr. HOBSON. You do not think you will get to the cap problem that will cause, or could cause, the problem with quality and rationing?

Dr. THORPE. Absolutely not. We think the backup mechanism is simply there as a backup mechanism. The likelihood as the system is implemented of having to rely on that, we do think is not very high. We think the savings we will get through the program of alliances and health plans, negotiating through administrative savings will be sufficient to generate the year-to-year growth.

Mr. HOBSON. There can be honest disagreement about that because of things that happened in the past. There is some skepticism, you know, about what these costs really are, or what they will be in the future. We have to see where we are when we get there.

Dr. FEDER. I think, as Ken indicated, I think our concern is that we need to promote the changes in the delivery system and enable us to pursue those savings.

Mr. HOBSON. We do not disagree.

Dr. FEDER. To go to your other two questions, essentially on Wal-Mart, Wal-Mart will be treated like all other businesses. Essentially, it is required to provide coverage to its workers. As a large business, it has the option to either self-insure, to add its own alliance—I believe it has 5,000 employees nationwide—or it has the option to come into the alliance. If it comes into the alliance, then its access to the discounts, the 7.9 percent discount occurs at a later date, because we are concerned about having a problem in which some businesses who would benefit enormously would select in and out. We have been attending to that.

The part-time workers would—part-time workers do obtain coverage through the regional alliance because that makes it easier.

Mr. HOBSON. So there is a theory that they could get subsidized, or if you took a 900-employee company, they could get subsidized, even if they were extremely profitable. In part because of the makeup of their work force—

Dr. FEDER. The focus is on the worker and the wages of the worker and affordability.

Very quickly, should I answer the fee-for-service question?

You raised the question about the validity of a fee-for-service promise. Actually, in the discussions we had with many economists, there are some arguing that changing the system the way we are

doing allows the survival of fee-for-service plans. We are holding all plans, whether they are HMOs, fee-for-service plans accountable for delivering the guaranteed package, based on their premium.

Now a fee-for-service, an open fee-for-service plan that does not have contracts and has more difficulty negotiating or managing its providers in that regard, does have tools. It essentially has a couple of kinds of tools. One is that it uses a rate schedule, and holds the providers accountable for delivering services based on that rate schedule.

It also has the capacity to focus, if rate reductions are needed, to focus on the providers who can be identified as delivering excessive services. There are systems included in the proposal that will enable providers and managers of any plan to know what services providers are providing and to essentially adjust payments appropriately for providers that are out of line. That is a tool that is not used widely today and would be available under this approach.

Mr. HOBSON. I would be interested in knowing who is talking about fee-for-services surviving under your plan. I would be interested in knowing who the outside economists were that you talked about earlier who looked at your overall plan. I think for credibility that that is a good list for people to know.

Thank you, Mr. Chairman.

Chairman SABO. Let me ask you this question: I assume as one looking at this, clearly for employers who offer no insurance today, they are going to have increased costs?

Dr. FEDER. That is right.

Chairman SABO. Or individuals who have no insurance today, they are going to pay more to have insurance?

Dr. FEDER. They are a little different. They may be paying out-of-pocket.

Chairman SABO. Maybe. Yes.

Dr. FEDER. Often are. I think that is a different proposition.

Chairman SABO. But there are a significant number of people who today do have comprehensive health insurance and the impact of controlling health care costs should be significant private savings for both those businesses and those individuals? I assume somewhere you have that collective estimate of total savings for those kinds of people?

Dr. THORPE. As I mentioned, we are in the process of looking at the change in national health expenditures over time as well as looking at the change a business spends, change in household spending, as well as the change in the Federal Government's spending.

I don't have the chart with me here today, but I can say that for each of those sectors, that the level of spending is going to be and will be lower by 1999 under this program than it is relative to the baseline. As you go out into the out years, 2000—

Chairman SABO. Just so I understand baseline, that means relative to doing nothing?

Dr. THORPE. Relative to doing nothing, using the CBO estimate of health care expenditures that came out last week.

Chairman SABO. In your program, there is no method of directly redirecting any of those savings for access or cost saving with busi-

nesses except the indirect fact you think additional revenues would be raised because of it?

Okay.

Mr. Smith?

Mr. SMITH OF MICHIGAN. Mr. Chairman, maybe a little bit of a follow-up. Let's say, for example, the wife works at one company and the husband works at another company. If one of those individuals says I would prefer additional leave time or additional salary, I am not going to take the health care benefits, that will result in an increased tax or reduced benefits because both of them are going to be obligated to pay through their company; is that correct?

Dr. FEDER. I would state it somewhat differently. I think essentially the employer who has been bearing the full burden and essentially carrying the obligation of the other employer, will now be sharing it with the other.

Mr. SMITH OF MICHIGAN. Some employers say if you do not want the health care plan, we will actually increase your salary to the extent it doesn't cost us any more money. Some employers do have a menu. In this case, in this plan, that option is no longer there. That family is going to have to pay more, even if they previously had the option of taking money instead of insurance?

Dr. FEDER. No. The family will not pay more.

Mr. SMITH OF MICHIGAN. But the business—

Dr. FEDER. One of the employers will pay less. Essentially, I would say the family comes out fine. There is a fair sharing across employers.

Mr. SMITH OF MICHIGAN. Now both parties have to pay towards that?

Dr. FEDER. Yes.

Mr. SMITH OF MICHIGAN. On the tobacco tax revenues, did you consider the impact of a 75-cent increase and its effect on CPI? Tobacco products make up about 2 percent of the total of CPI. An increase of about 75 cents per pack of cigarettes alone will result in a CPI increase of between .7 and 1 percent. If it is .7 percent, it will cost the Federal Government because of its effect on COLA payouts, \$4 billion a year over the next 5 years or \$20 billion. And, if States follow that lead, which many States are now proposing between a 55- and 75-cent sin tax on tobacco products, even that figure would increase. The result is an increase in outlays because of the effect of a CPI increase on COLAs. In addition, Federal income tax returns for the earned income tax credit would increase as well because of stair-stepping that is now geared to inflation, or an annual total cost of \$6 billion for the 75 cent tax increase. Has that all been computed and subtracted out of your anticipated revenues for a tobacco tax increase?

Dr. THORPE. I don't think the premise is correct. I think that that is—in order to be precisely—to give you the precise answer you need, since the estimates of this were done by the Treasury Department and will be done by joint tax, we used similar conventions. The specifics about the assumptions of change in CPI, if any, which I do not think—but that type of detail would best be provided by them.

Mr. SMITH OF MICHIGAN. CBO says tobacco represents 2.3 percent of the market basket of goods now used to determine the

CPIW used to inflate government payment programs. I am introducing a bill that would develop a new CPIG that takes tobacco out where it is used for expanding COLA benefits for Social Security, SSIs and other programs.

Dr. THORPE. To get the precise answer, I think you would be better off with them giving it to you, to recognize what is built into their capacity is looking at changes in utilization. As utilization changes, those weights over time will change as well.

Mr. SMITH OF MICHIGAN. You would hope so, but I understand they haven't changed for the last 8 years.

Let me ask you a question about young people, the low-risk, and probably the most likely to gain from being self-insured. We are going to require that younger person to pay the cost of these benefits even though it does have a cap of 3.5 percent of their wages?

Dr. FEDER. For the smallest business and lowest-wage workers.

Mr. SMITH OF MICHIGAN. For that young person, we are now going to require them, in order to—your words were, I think, “spread the risk”—we are going to require these low-risk individuals to start carrying insurance to help “spread the risk” which means that a young person who previously was not paying is going to have to start paying?

Dr. FEDER. The low-risk does not mean no-risk. I have a 22-year-old son, for whom I purchase health insurance.

Mr. SMITH OF MICHIGAN. Do I understand that my statement is correct? All of the young people that have decided, in some cases, at their own decision, that they would rather be self-insured than pay the \$300 a month, or whatever it costs, that they are now going to be required to carry insurance?

Dr. FEDER. Everybody is required. There are discounts to businesses and individuals to enable them to afford their responsibilities.

Mr. SMITH OF MICHIGAN. The other part of the problem with making people pay that usually don't use the service quite so much, is that I haven't seen a table, or any computations, that show the amount we are increasing the charge to these young people. In the sources of revenue you provided, we are increasing the charges to small businesses that currently are not paying anything. It might be the straw that breaks a small business' back. Is there any table that shows, here is the additional amount both the man and wife would have to pay and how much more revenue would come in? Is there any table that shows the additional amount young people would have to pay to carry insurance or the additional amount small business would pay?

Can you help me find the revenues that would come in because of those extra insurance payments?

Dr. THORPE. If I understand the thrust correctly that you are asking, what happens to somebody who is not insured, either the business doesn't provide insurance or the individual doesn't carry it, what happens to the amount of money they spend, the change in spending on health insurance, who are currently uninsured businesses and firms that currently do not provide it?

Mr. SMITH OF MICHIGAN. That is part of it.

Dr. THORPE. Those estimates as Judy mentioned, are complex because people who are uninsured today do spend a lot of money, in

some cases, for health care. They just spend it out-of-pocket. But we do have the changes in health spending for the currently uninsured.

Mr. SMITH OF MICHIGAN. I can give you a Congressional Research Service figure on that. An uninsured person uses only 24 percent of the health care services compared to those that are insured; and of that 24 percent—in other words, a person paying this reaches into their own pockets, they do not use as many health care services as those that are covered by insurance. I am disappointed you do not have more of a co-pay on every case as we go into this.

Here again, the estimate is that of the 24 percent of the health care services they use, compared to those that carry insurance, they paid for half of it themselves and the other half, or 11 percent, is passed on to those insured.

Dr. THORPE. I have to check the numbers. That does not seem to be consistent with the numbers I have seen in the research literature. Just to be clear, that does underlie our estimates. We are looking at people who do not have insurance today. What happens to the change in both public and private spending when they do have health insurance. As we get more detail, we would be happy to supply the information.

[The Health Security Act: A Financial and Distributional Analysis, appears at pg. 72.]

Chairman SABO. Mr. Hoke?

Mr. HOKE. Thank you, Mr. Chairman.

I had a couple of questions just for clarification. Is there a ceiling on the 7.9 percent of payroll? Are there any ceilings on that?

Dr. FEDER. In terms of level of payroll? No, I don't think so.

Is that what you mean?

Mr. HOKE. Individual levels? In other words, a physician who makes \$400,000 in payroll income?

Dr. FEDER. No. Essentially, this is a ceiling, as Ken indicated earlier, a ceiling on what is paid as an employer. They pay 80 percent of the premium or that 7.9 percent of payroll, whichever is less. So essentially if the payroll is very high, that cap becomes irrelevant. They simply pay the premium.

Mr. HOKE. To the health alliance?

Dr. FEDER. That is correct.

Mr. HOKE. But not to the insurance company?

Dr. FEDER. If they are in the regional alliance, they pay to the alliance; that is correct.

Mr. HOKE. In the line item on page 2, financing health care reform, uses of funds, new Federal administrative start-up costs, \$9.6 billion in there. How many jobs, how many new employees does that require or does that contemplate?

Dr. THORPE. I am not aware we have made any projections of that. Of course, there's going to be—

Mr. HOKE. How did you come up with that amount?

Dr. THORPE. I think you are asking about the net new jobs. We have not done projections about the impact this would have on change in jobs within existing agencies that oversee health programs. This would be sort of newly targeted money. But in terms of changes in spending and other HHS, Labor, Commerce, and so

on, I don't have those figures here with me. I don't have the net job—

Mr. HOKE. How many gross new jobs?

Dr. THORPE. I don't have the backup on the line item with me.

Mr. HOKE. Could you get that to me, please?

[The Costs of Failing to Reform Health Care, by Laura D'Andrea Tyson, dated October 6, 1993, appears at pg. 129.]

Mr. HOKE. In the Medicare drug benefit, benefits, administration of pharmacists costs, less rebate. There is a new administration, also. Can you tell me how many employees are contemplated in that line?

Dr. THORPE. My recollection is that we assumed the administrative costs are approximately 10 percent of the program benefits. But, again, in terms of specific changes in organization or jobs that are focused on that, I would have to provide the information to you for the record.

Mr. HOKE. I would like that. We have on the one hand a reinvent government program that is supposed to eliminate as many as a quarter of a million jobs; and so I think Congress is intensely interested in how many new Federal employees are contemplated in the administration, lines that would not be.

If there are any other new Federal employees, gross, not net, and if you want to net it out against jobs for jobs lost in other areas of HHS, that is great. If there are any other areas within the President's health reform package, where there would be new employees, I would like information on that.

[The Health Security Act: A Financial and Distributional Analysis, appears at pg. 72.]

Mr. HOKE. One other clarification, with respect to the 17 percent rebate, from drug companies to the Federal Treasury for Medicare-branded drugs, I just wanted to explore that a little bit.

How exactly does that work? Somebody sends in the reimbursement to Medicare for the drug or—explain that.

Dr. FEDER. Well, I think essentially this is a calculation that does lead to a—it is essentially—leads to a reduction in the price Medicare would pay. I don't know whether—I cannot answer your question.

Is there anybody on the staff?

We will have to get that. I am sorry. We will get back to you on that.

[The information follows:]

The basic rebate under the Medicare outpatient drug program is paid directly to the Medicare program (HCFA) by manufacturers for each product sold to Medicare beneficiaries. Pharmaceutical manufacturers wanting coverage for their products, must sign rebate agreements with the Secretary of HHS and report what the average retail and average non-retail prices are for their products. Based on claims data submitted by pharmacists, Medicare determines beneficiary utilization for each drug product. The basic rebate is then calculated; the greater of 17 percent of the average retail price or the difference between the average retail price and average non-retail price; and an invoice is sent to manufacturers. Manufacturers pay rebates on a quarterly basis.

Mr. HOKE. You use the word "rebate." "Rebate" is different from "discount." Rebate implies somebody pays for something.

Dr. FEDER. Again, I can speak to you very generally about it. It was originally a design—although this is quite different in design

from what has been put in the law with respect to the Medicaid program, that arrangement would no longer be in operation because Medicaid is part of the premium.

Are you saying it is a discount and not differently calculated?

We will get back to you on it.

[The information follows:]

The Health Security Act will make the Medicare program one of the largest purchasers of medications in the world. The Administration believes it is essential to assure that Medicare receive a price benefit as a large purchaser to help it contain its prescription drug costs. Because Medicare is a fee for service program, it does not bulk purchase drugs up front for Medicare beneficiaries. Beneficiaries purchase drugs for their own use on an as needed basis. Due to administrative ease, the rebate program is better suited to assure prescription drug cost containment for Medicare, because the rebate is calculated once utilization quantities are known.

Mr. HOKE. Have you done any studies with respect to that on the impact on research and development for new drugs that is going to result from clipping brand drugs from large pharmaceutical companies by 17 percent?

Dr. FEDER. Just broadly. I will let Ken follow up. We have been very concerned about that. Essentially, when you look at that, what happens overall to the pharmaceutical industry under reform, what you can see is a significant improvement in demand for pharmaceuticals, once everybody is covered, which they are not now. Whether they are young or old, they will have coverage. That increases the demand.

The bulk of the system will be operating in terms of the deliveries—

Mr. HOKE. Your health plan increases demand. It does it on paper. Are you suggesting there are a lot of people who are not getting the drugs they need?

Dr. FEDER. I will provide you for the record the precise assumptions that have been used. I think essentially there is some increase in use.

Mr. HOKE. All the people that are older, they have got a Part B?

Dr. FEDER. They do not have drug coverage right now on Medicare. We are adding that. Some of them have it through medigap coverage. We know there are many seniors who cannot afford drugs today.

We would be happy to provide that to you as there are uninsured younger Americans or Americans of limited insurance who do not have that coverage. So there is—just as your colleague was indicating, there are changes where people get coverage in terms of the services they provide. So there is an expansion. A lot of it is handled through the private sector health plans dealing with drug companies and negotiating the prices, as they are increasingly doing today, and so we are relying on that system. As the pharmaceutical industry—I am sorry, too long.

[Methodological Description of Health Care Reform Premium and Discount Estimates, appears at pg. 139.]

Chairman SABO. I am sorry. We have Mr. Cooper and Mr. Shays left. Our witnesses have to leave by 12:30.

Mr. Cooper?

Mr. COOPER. I am going to be brief. Now, I really have to be brief. I appreciate the panelists work in this very complicated area. It is not easy to do. I appreciate your expertise.

It seems to me like we are moving beyond the car sale stage into the mechanical stage now, actually lifting the car and seeing how it will work. These are, as I see, very complicated, detailed questions.

I was particularly interested in Dr. Feder's testimony on Page 12, where I think you say, virtually universal coverage. It seems there was a striking note of increasing realism in the debate. I think everyone acknowledges universal coverage is the goal we should have, but it is very difficult to achieve. It is not a black or white issue.

I think the sentiment is together these changes will result in virtually universal coverage of our population. It is not stated there, but I imagine the target date is January 1, 1998?

Dr. FEDER. End of 1997. You do recognize, Congressman, on undocumented immigrants, workers do not have the guaranteed package. Otherwise, I believe we do achieve universal coverage. We were being quite precise in that.

Mr. COOPER. How does the employer achieve coverage of everyone except undocumented aliens?

Dr. FEDER. Essentially, the system as a whole achieves universal coverage by establishing a payment system in which everyone contributes, and an obligation on employers and individuals to enroll.

Mr. COOPER. It was my impression in Hawaii, for example, where they had coverage for 20 years, they still do not have universal coverage in the sense of 100-percent coverage. It is easier to know that in Hawaii than in the District of Columbia.

Dr. FEDER. In Hawaii there have been limits on the coverage of employers. We cover all employers and dependents, all sizes of employers and do provide supports for people when they lose their jobs. I think it is a more comprehensive system.

Mr. COOPER. It was my impression that 30 percent of the uninsured today have no contact with an employer whatsoever, no family member works. How does an employer mandate reach those people?

Dr. FEDER. What we have established is that some of the people who are most difficult to reach, are people who are not operating in the workplace and who are in disadvantaged circumstances. We have what we call a "point-of-service" enrollment, to guarantee everybody service when they need it and providers payment when they arrive. We have a mechanism for enrolling them at that point.

Mr. COOPER. At that point, which is when they need care?

Dr. FEDER. Yes. Essentially, if there are resources involved, with obligations to make up the payments that were not made.

Mr. COOPER. If you are a healthy individual and do not need emergency room care for 10 years, then you would be enrolled in the 10th year.

Dr. FEDER. If you never have gone near a job, you would owe a heck of a lot of money when you got there.

Mr. SMITH OF MICHIGAN. Better go to Canada after that.

Mr. COOPER. We ought to figure out a way to reach universal coverage in a cost-effective way. I have just been concerned the employer mandate might not necessarily be the best way to do it, to be sure, the same way of getting part way home, but it is not a way of getting all the way home.

I realize time is short. I don't want to make my colleague, Chris Shays, delay any longer.

I appreciate the hard work and expertise you contributed to this process.

Dr. FEDER. Thank you, Congressman, as usual.

Chairman SABO. Mr. Shays?

Mr. SHAYS. I thank both of you for being here. Your responses were very helpful. I appreciate your open attitude.

I also want to say that I think we are dealing with this issue for the very reasons my Chairman described, that too many people have no health insurance and the system has gotten so expensive. Those who do not have health insurance are still being covered. I buy on to those two arguments.

I mean this in all sincerity, that I am extraordinarily grateful to the President and his staff for the fact that they have focused the Nation's attention on this issue. It is a delight to be dealing with real and important issues in Congress instead of some we have been dealing with for the past few years.

Having said that, I have a concern that I will commit the same mistake I did as a freshman legislator when I voted for the Catastrophic Health Care Bill. I want to say to you that the thought in 1998, that it will cost \$30 billion over 5 years, and in August of 1989, finding it was going to cost \$48.3 billion, a 50-percent increase in our estimates, is very unsettling. It is unsettling to me when we see technical changes to entitlements which can mean that we underestimated the number of people involved. But there were changes we had to make that saw the numbers change in Medicaid by \$100 billion and Medicare by \$51 billion over 5 years.

It is unsettling to me when we insert in the 1990 agreement changes Henry Waxman wanted to Medicaid, and allowed certain people, young people to be phased in from age 5 to 17, and finding that that is much more expensive than we thought.

So I don't have a sense of being comfortable with estimates. These are modern-day people making these estimates, the same people that are helping you.

I just was going to say that to you. Which leads me to the question, why don't we prove the savings before we expand the benefits?

Dr. THORPE. Again, let me start with the first part of your question. I would just refer back to the initial part of my testimony about the process of how the estimates were derived, both internally as well as—

Mr. SHAYS. I heard those. I am just sharing my concern with you. The question I am asking, though, is why don't we prove the savings before we expand the benefits?

Dr. FEDER. I think, Congressman, it is very difficult to achieve the savings that we are talking about without having everybody in the system. As we have indicated several times, we feel that the critical change that needs to occur to achieve the savings in the health care system, is a change in the delivery system, a change in which we are able to hold practioners responsible for delivering care efficiently, in which they can expect to be paid; but they, then, are responsible for managing care efficiently.

We also need to have a system in which we cannot cost shift from one payer to another. And that requires that everybody be in the system.

To move incrementally leaves chasms in this system. In fact, that was part of the reason Medicaid costs went up so dramatically, as you indicated. That was one of the problems.

Mr. SHAYS. That was part of the problem. I buy part of that argument. There are certain savings that could go into effect and certainly we would not have to expand some of the benefits, the early retiree benefit, the long-term care benefit, pharmaceutical benefits; these are new entitlements.

What I am troubled with as a budget person, is I say 50 percent of our budget is entitlements, 34 percent is discretionary, 16 percent is interest on the national debt.

And we need to control the growth of entitlements, and at the same time I am telling people that we need universal coverage. How do I get around the argument with my constituents that I am saying we need to see less entitlements and now being asked to vote on a gigantic new one?

Dr. FEDER. I think what you need is responsible protection for individuals, and I think that your constituents are also seeking security of coverage.

When it comes to your senior constituents, the absence of protection in long-term care is bankrupting families, and I think they are well aware of that. And the design of that program, as the rest of the system, is not open-ended. It is designed in a responsible manner that holds the system accountable for living within its estimates.

Mr. SHAYS. Let me just deal with that, though. I mean, I read the article in the Post today where my colleagues, Mr. McMillan and Henry Waxman, questioned you on the whole issue of caps. What benefit is a cap if we exceed the cap? We come to the Federal Government and say you have to come up with the money?

Dr. FEDER. I think, essentially, what the cap does—and I think that we indicated earlier why it is we don't expect to reach that cap—but should that happen, it is essential that elected officials be held accountable for assessing the system.

You have raised—you and your colleagues have raised a number of questions this morning about the operation of the system and whether it is working, and if it weren't, why it isn't working. We need to have a mechanism that enables those questions to be raised should it be necessary. That is why we have it.

Mr. SHAYS. The problem is, Doctor, that once I vote in this program and there is an expectation—if the individual who doesn't understand there is a cap, the government is going to come up with the money. I respect the fact that you believe that your estimates are 15 percent under. I respect that. But a cap is really not a cap. What you are really saying to me is, when we reach that number we will come to Congress to appropriate additional monies.

Dr. FEDER. Well, I think that, essentially, one would have to look at what the difficulties were that led the cap to being breached, and I think that that would be the issue, and I think that that is the job of elected officials, to take responsibility for the programs they are operating.

Mr. SHAYS. Just one last point, and that just deals with my sense that you get universal coverage by the fact that 85 percent of those who aren't covered by health care are employed, and, therefore, if you tell employers they pay for it, they will be covered. How do you get at the argument that a lot of these businesses that are marginal will do two things: They will cut back or they will simply go out of business?

Dr. FEDER. Essentially, we have been quite concerned, as we indicated throughout, about the obligations on businesses who have not previously been paying. That is why we have developed a discount schedule that protects those—the wages and jobs of those employees who most need protecting.

Mr. SHAYS. I would just say to you in speaking to some of these businesses they don't feel they are protected, and I think this is an issue that I am going to pay a lot of attention to. The bottom line for me is I don't want to vote for a program and then have someone come to me 3 years later and say you bankrupted the country. Your numbers weren't accurate.

So I just hope we haven't built overexpectation on the part of the public that the President's plan is going to provide all of these benefits. I hope there is a realistic assessment on the part of the public of what it is going to cost.

Thank you both very much. Thank you, Mr. Chairman.

Chairman SABO. Thank you.

Without objection, questions and statements submitted by members will be included in the record.

I want to thank both of you for your testimony today. You truly have done a remarkable job in answering lots of very, very detailed questions.

What you are about is incredibly important. Clearly, we have to control costs in the system. My own judgment is that to move to universal coverage is incredibly important. To move to universal access would be important but not nearly—and not all that difficult to do. But to deal—to move to the position where we do have universal coverage I think produces lots of the questions that members have of you, of how we fund it and how the system works, and I think you have done a great job in responding to those questions today.

I expect our committee and its members will continue to have questions of you and other members of the administration in the months ahead, and we look forward to continuing to work with you.

Dr. FEDER. Thank you, Mr. Chairman.

Chairman SABO. Thank you very much for a very productive hearing.

[Whereupon, at 12:35 p.m., the committee was adjourned.]

[Additional material submitted for the record follows.]

**THE HEALTH SECURITY ACT:
A FINANCIAL AND DISTRIBUTIONAL ANALYSIS**

**THE HEALTH SECURITY ACT:
A FINANCIAL AND DISTRIBUTIONAL ANALYSIS**

I. NATIONAL HEALTH EXPENDITURES

II. IMPACT ON FEDERAL GOVERNMENT

III. IMPACT ON BUSINESS

IV. IMPACT ON FAMILIES

THE HEALTH SECURITY ACT: A FINANCIAL AND DISTRIBUTIONAL ANALYSIS

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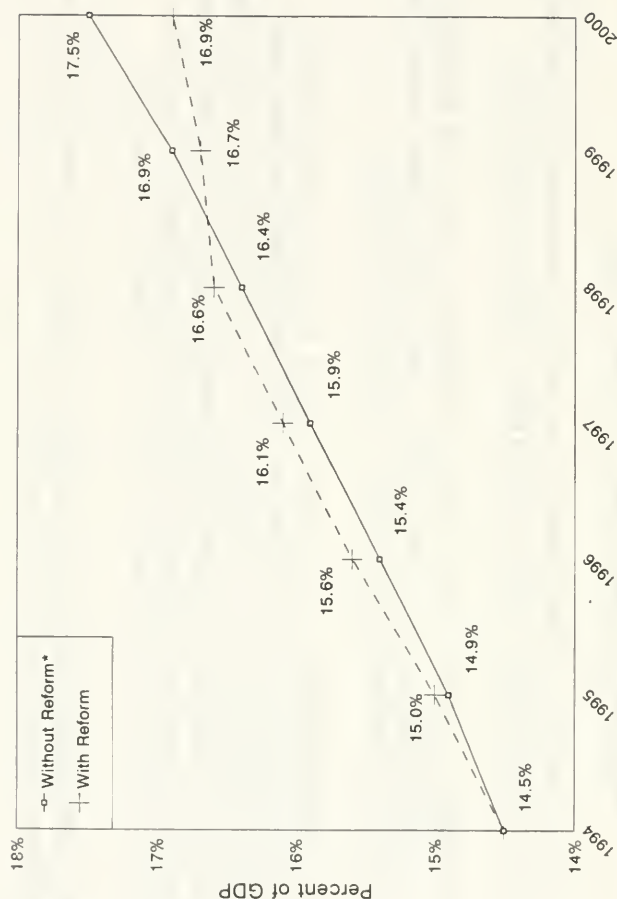
NATIONAL HEALTH EXPENDITURES

NATIONAL HEALTH EXPENDITURES UNDER CURRENT POLICY AND THE HEALTH SECURITY ACT: 1994 - 2000

- Absent comprehensive reform, health care would consume 17.5 percent of GDP, or \$1.653 trillion, in the year 2000. [Charts I-A and I-B]
- Under the Health Security Act, health care will consume 16.9 percent of GDP, or \$1.597 trillion, in the year 2000. This is \$56 billion lower than if there were no comprehensive reform. [Charts I-A and I-B]
- Under the Health Security Act, there will be a short-term increase in national health expenditures. Between 1995 and 1998 national health expenditures will consume 0.1 percent to 0.2 percent more of GDP than they would have without comprehensive reform. By 1999, health care will consume a lower percentage of GDP under the Health Security Act than if there were no comprehensive reform. [Charts I-A and I-B]
- Over the entire period from 1994 to 2000, savings will exceed additional expenditures by \$37 billion. [Chart I-B]

NATIONAL HEALTH EXPENDITURES AS A PERCENT OF GDP

Under Current Policy and the Health Security Act: 1994 - 2000



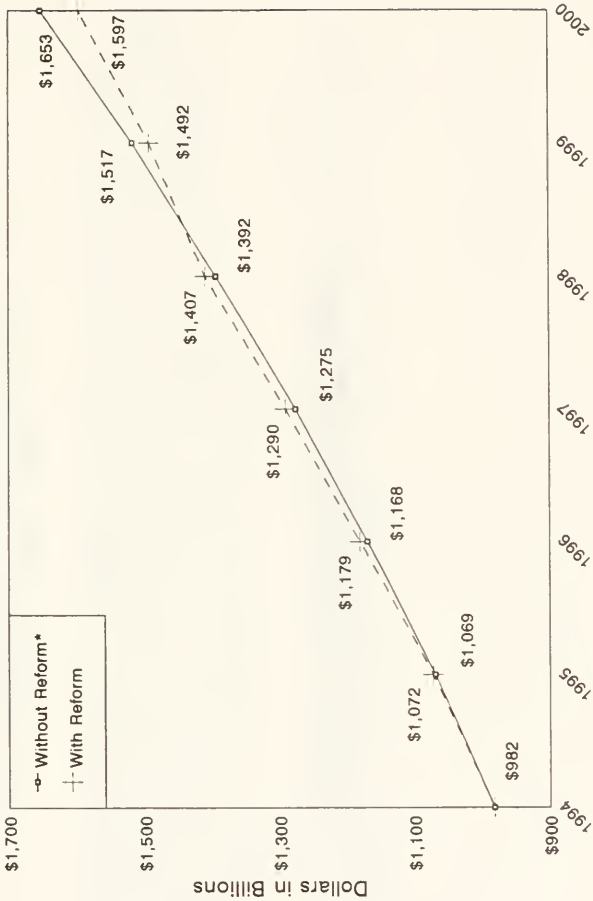
SOURCE: Administration Estimates.
* CBO baseline with Administration's economic assumptions.

Chart I-A

3

NATIONAL HEALTH EXPENDITURES IN DOLLARS

Under Current Policy and the Health Security Act: 1994 - 2000



SOURCE: Administration Estimates.
 * CBO baseline with Administration's economic assumptions

Chart I-B

IMPACT ON FEDERAL GOVERNMENT

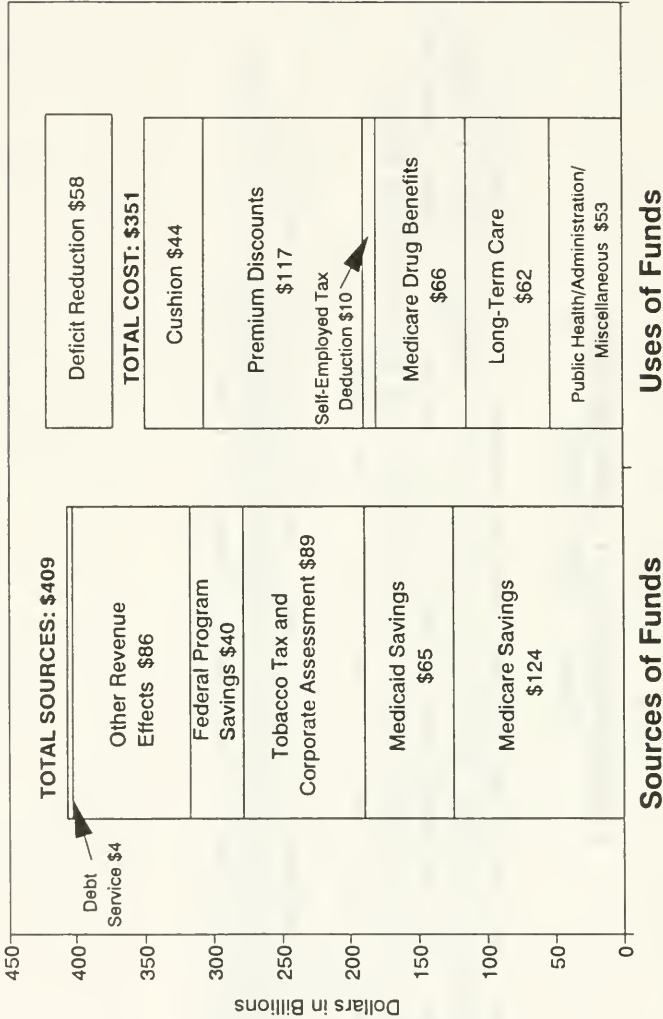
FINANCING HEALTH CARE REFORM

Totals: 1995 - 2000

- Under the Health Security Act, federal sources of funds (savings and resources) will total \$409 billion for the period 1995 to 2000. The total federal cost (expenditures) of health reform will be \$351 billion over that period. Thus, health reform will contribute \$58 billion toward deficit reduction in the first five years alone. [Chart II-A]
- The total estimated cost includes a \$44 billion discount "cushion", designed to ensure that there is adequate funding in the event of unanticipated economic or behavioral changes. [Chart II-A]

FINANCING HEALTH CARE REFORM

Totals: 1995 - 2000



SOURCE: Office of Management and Budget
Totals may not add due to rounding

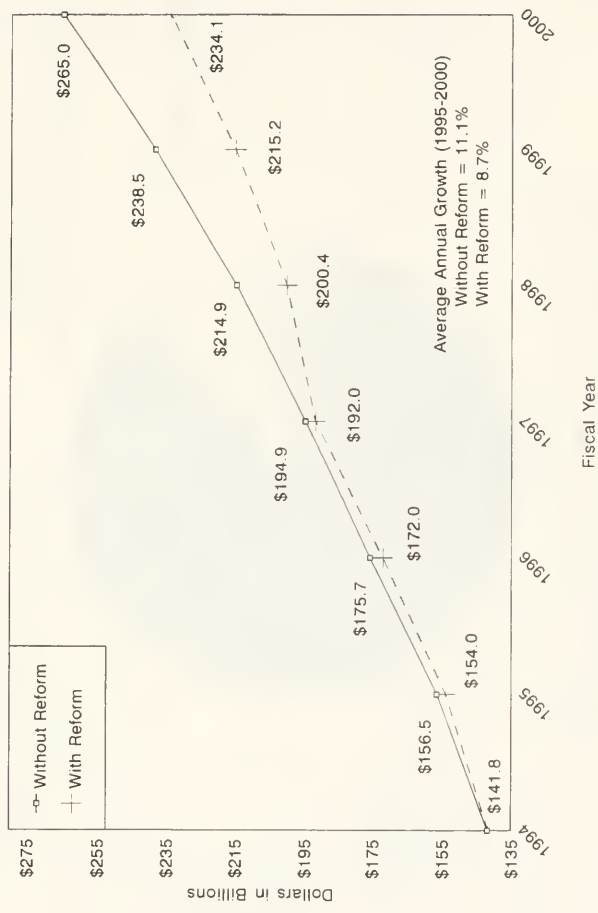
MEDICARE PROGRAM UNDER CURRENT POLICY AND THE HEALTH SECURITY ACT: 1994-2000

- Absent comprehensive reform, Medicare spending would grow at an average annual rate of 11.1 percent from 1995 to 2000. [Charts II-B and II-C]
- Including spending for the new prescription drug benefit, Medicare expenditures under the Health Security Act will increase at an average annual rate of 8.7 percent from 1995 to 2000. This is an average decrease of 2.4 percentage points due to the Health Security Act. [Chart II-B]
- Without spending for the new prescription drug benefit, Medicare expenditures under the Health Security Act will increase at an average annual rate of 7.2 percent for the same years. This is an average decrease of 3.9 percentage points due to the Health Security Act. [Chart II-C]
- Not including spending for prescription drugs, the Health Security Act will reduce Medicare spending by \$47.1 billion in the year 2000 alone. If spending for prescription drugs is included, Medicare spending will drop by \$30.9 billion in that year. [Charts II-B and II-C]

- Only 13 percent of all Medicare savings will be financed by beneficiaries. These savings will result from provisions such as coinsurance for home health care and laboratory services. [Chart II-D]
- Beneficiaries with annual incomes over \$90,000 for individuals and \$115,000 for couples will pay higher Part B premiums.
- Older Americans will pay an additional \$11.00 a month for the prescription drug benefit.

THE MEDICARE PROGRAM* UNDER THE HEALTH SECURITY ACT

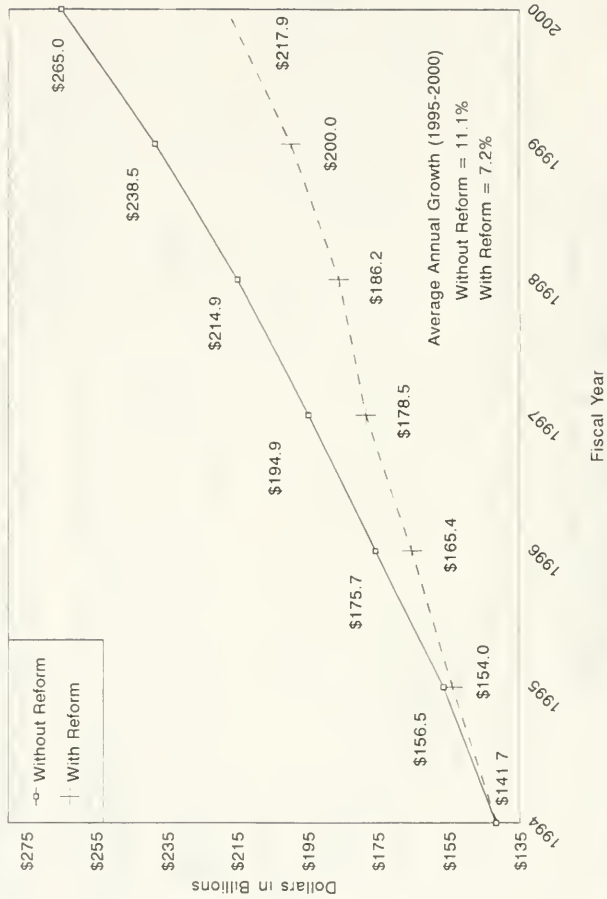
Growth With and Without the Health Security Act
(With the Prescription Drug Benefit): 1994 - 2000



SOURCE: Office of the Actuary, HCFA
* Net of Offsetting Receipts
The proposed Medicare drug benefit becomes effective in 1996.

THE MEDICARE PROGRAM* UNDER THE HEALTH SECURITY ACT

Growth With and Without the Health Security Act
(Without the Prescription Drug Benefit): 1994 - 2000



SOURCE: Office of the Actuary, HCFA.
* Net of Offsetting Receipts

SOURCES OF MEDICARE SAVINGS

Beneficiaries v. All Other: 1995 - 2000



SOURCE: HHS, OASMB

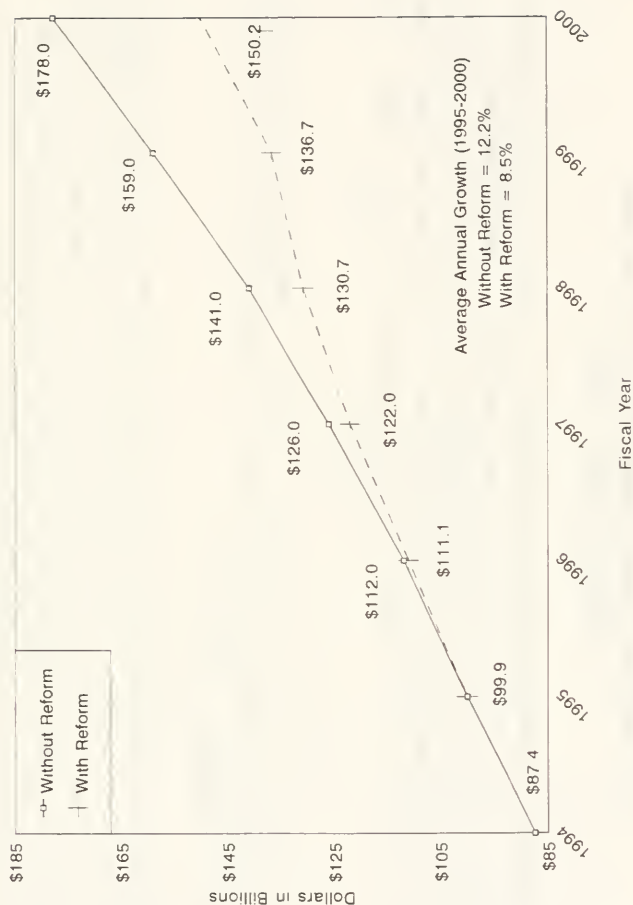
Chart H-D
17

MEDICAID PROGRAM UNDER CURRENT POLICY AND THE HEALTH SECURITY ACT: 1994-2000

- Without comprehensive reform, federal spending for Medicaid would grow at an annual rate of 12.2 percent from 1995 to 2000. [Chart II-E]
- Under the Health Security Act, federal Medicaid spending will increase at an annual rate of 8.5 percent for the same years. This is an average decrease of 3.7 percentage points due to the Health Security Act. [Chart II-E]
- The Health Security Act will save \$27.8 billion in federal Medicaid spending in the year 2000 alone. [Chart II-E]

THE MEDICAID PROGRAM UNDER THE HEALTH SECURITY ACT

Growth With and Without the Health Security Act*



SOURCE: Office of the Actuary, HCFA
 * Federal expenditures only

Chart II-E

14

COST OF DISCOUNTS

For Families, Businesses, and Early Retirees

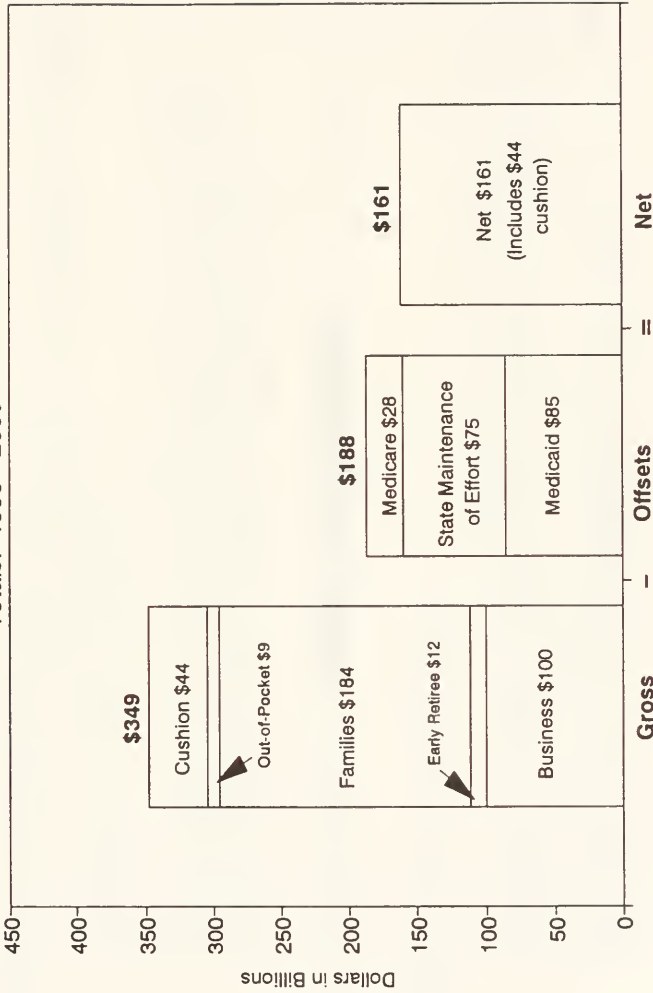
Totals: 1995 - 2000

- The federal government will provide discounts totalling \$349 billion for the period from 1995 to 2000. This cost will be partially offset by \$188 billion which will be saved because some persons who used to be in public programs will move into alliances. Thus, the net cost of the discounts will be \$161 billion for the period from 1995 to 2000. [Chart II-F]
- The net cost includes a \$44 billion "cushion", designed to ensure that there is adequate funding in the event of unanticipated economic or behavioral changes. [Chart II-F]
- Excluding the cushion, about \$184 billion (60 percent of the total cost) will be used for premium discounts for families. About \$100 billion (33 percent) will be for discounts to businesses. Approximately \$12 billion (4 percent) will be for discounts for early retirees, and \$9 billion (3 percent) will be for individuals' out-of-pocket expenses. [Chart II-F]

COST OF DISCOUNTS

(For Families, Businesses, and Early Retirees)

Totals: 1995 - 2000



SOURCE: Office of Management and Budget

Chart II-F

IMPACT ON BUSINESSES

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT: 1994 - 2000

Absent comprehensive reform:

- Employer premium payments will increase from \$180 billion in 1994 to \$303 billion in 2000. [Chart III-A]
- This correlates to an increase in percent of payroll spent on health insurance from 5.8 percent of total payroll to 7.0 percent of total payroll, and an increase in per worker premium expenditures from \$1,540 in 1994 to \$2,473 in 2000. [Charts III-B and III-C]
- This represents an overall increase in premium payments of nearly 70 percent.

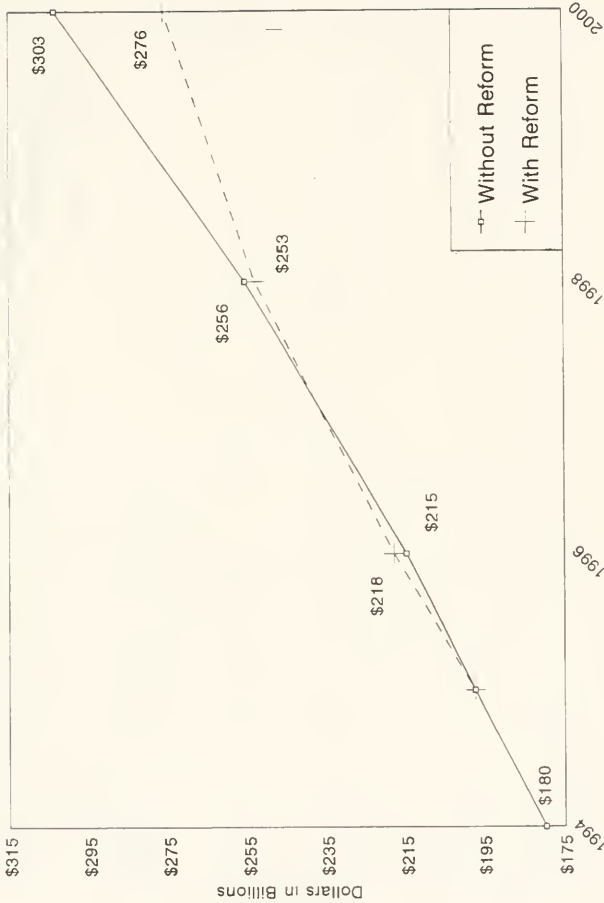
Under the Health Security Act:

- Employer premium payments will only rise from \$180 billion in 1994 to \$276 billion in 2000 -- **\$27 billion less** than would have been the case without reform. [Chart III-A]
- This correlates to a smaller increase in percent of payroll spent on health insurance -- only 6.4 percent with reform. [Chart III-B]

- Per worker premium expenditures increase at a slower rate, from \$1,540 in 1994 to \$2,245 in 2000. [Chart III-C]

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Annual Employer-Paid Premiums: 1994 - 2000

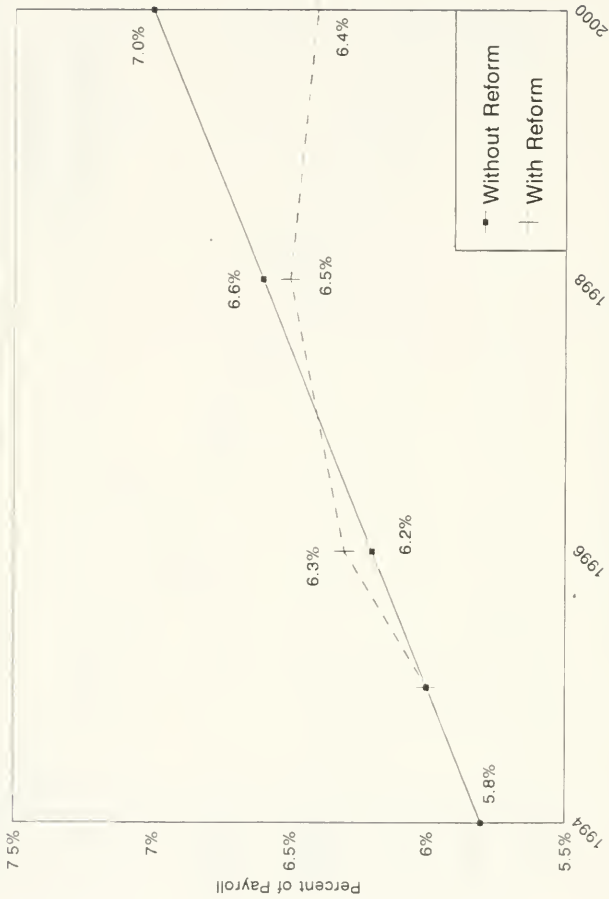


SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

Chart III-A

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Percent of Payroll: 1994 - 2000



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and individual markets.

Chart III-B

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Premiums per Worker: 1994 - 2000

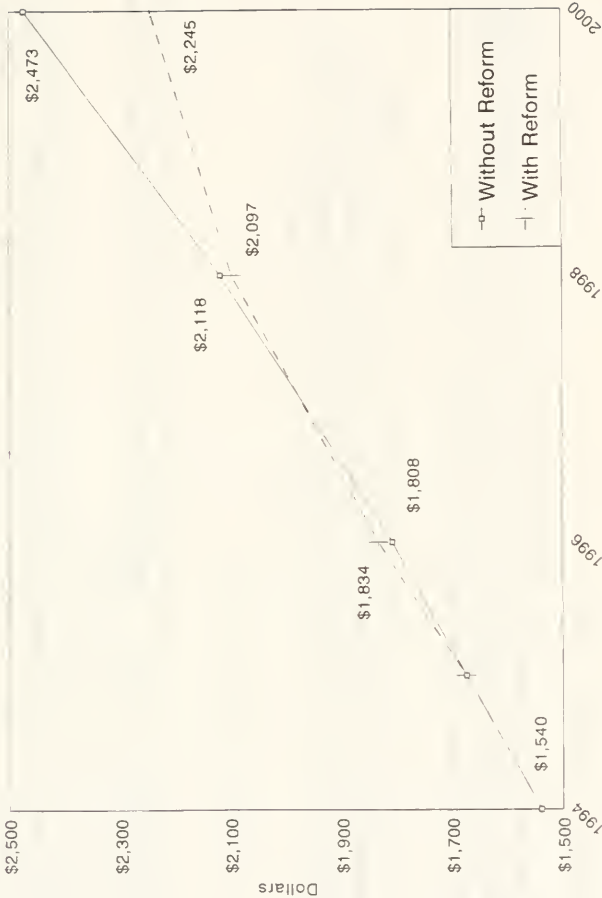


Chart III-C

SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts includes premiums paid by public and private employers for covered services in corporate and regional alliances

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

For Firms Currently Offering Insurance: 1994 - 2000

Absent comprehensive reform:

- Employer-paid premiums for firms that currently offer insurance would rise at a rate of approximately 70 percent, from \$180 billion to \$303 billion between 1994 and the year 2000. [Chart III-D]
- This results in an increase in percent of payroll spent on health insurance from 6.8 percent of total payroll to 8.2 percent of total payroll, and an increase in per worker premium expenditures from \$1,923 in 1994 to \$3,086 in 2000. [Charts III-E and III-F]

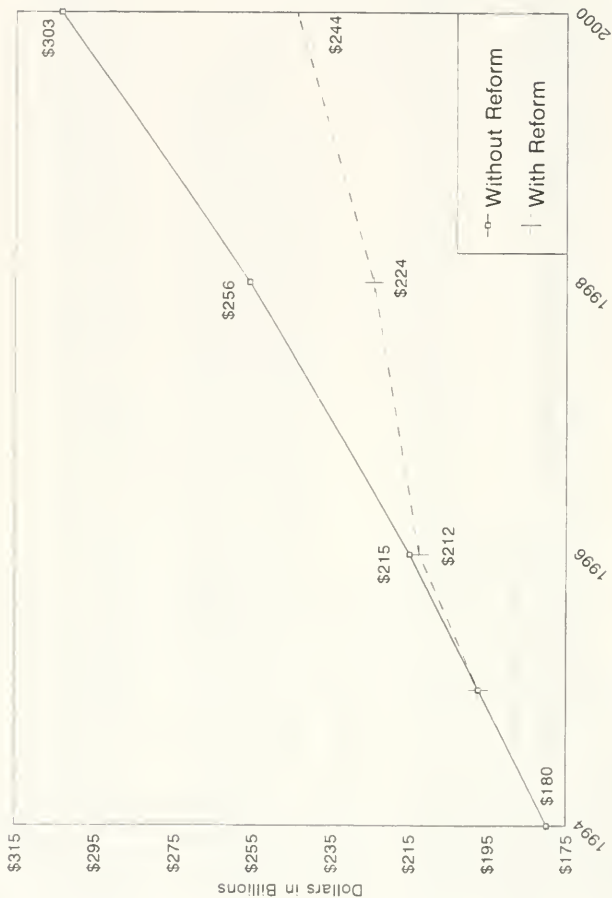
Under the Health Security Act:

- Employer premium payments will rise from \$180 billion in 1994 to only \$244 billion in 2000 -- **\$59 billion less** than would have been the case without reform. [Chart III-D]
- This results in a smaller increase in percent of payroll spent on health insurance -- only 6.6 percent with reform, versus 8.2 percent without reform. [Chart III-E]

- Per worker premium expenditures increase at a slower rate, from \$1,923 in 1994 to \$2,481 in 2000, an overall increase of only 29 percent. This equates to savings of \$605 per worker in the year 2000. [Chart III-F]
- Under the Health Security Act, employers who now offer insurance will experience immediate savings.

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Annual Employer-Paid Premiums for Firms Currently Offering Insurance: 1994 - 2000



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Percent of Payroll for Firms Currently Offering Insurance: 1994 - 2000

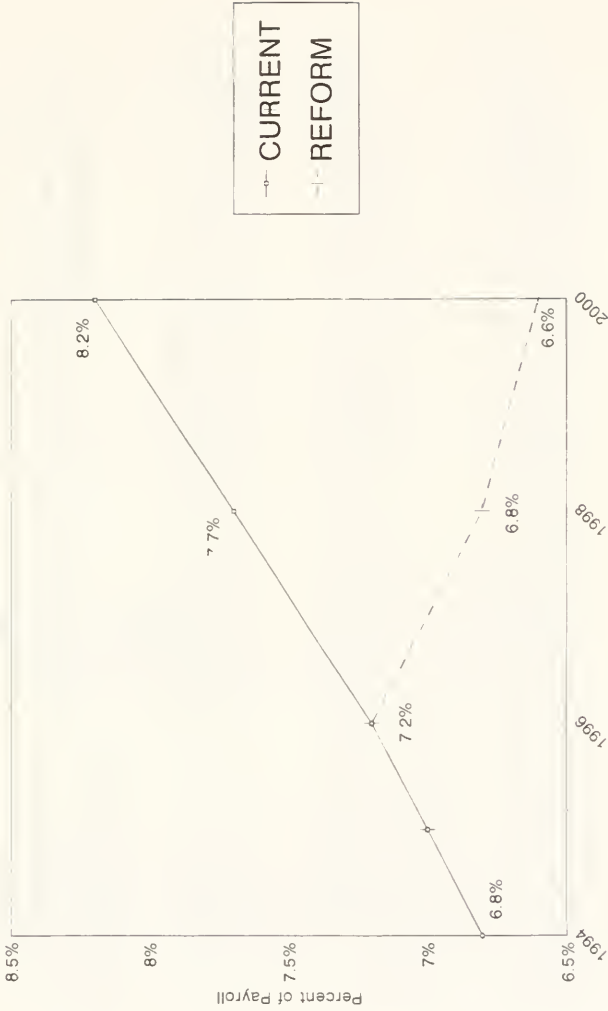
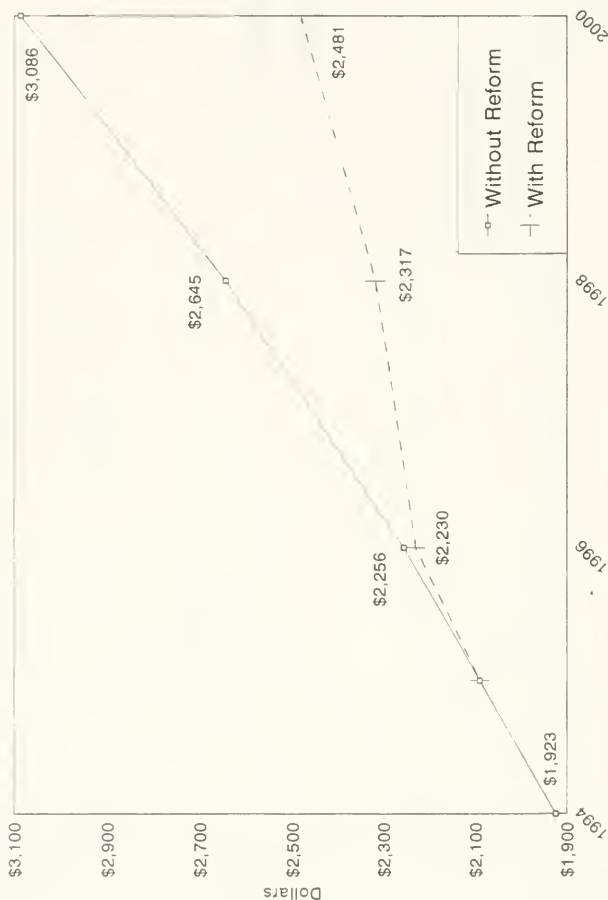


Chart III-E

SOURCE: HHS and The Urban Institute's THIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Premiums per Worker for Firms Currently Offering Insurance: 1994 - 2000



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

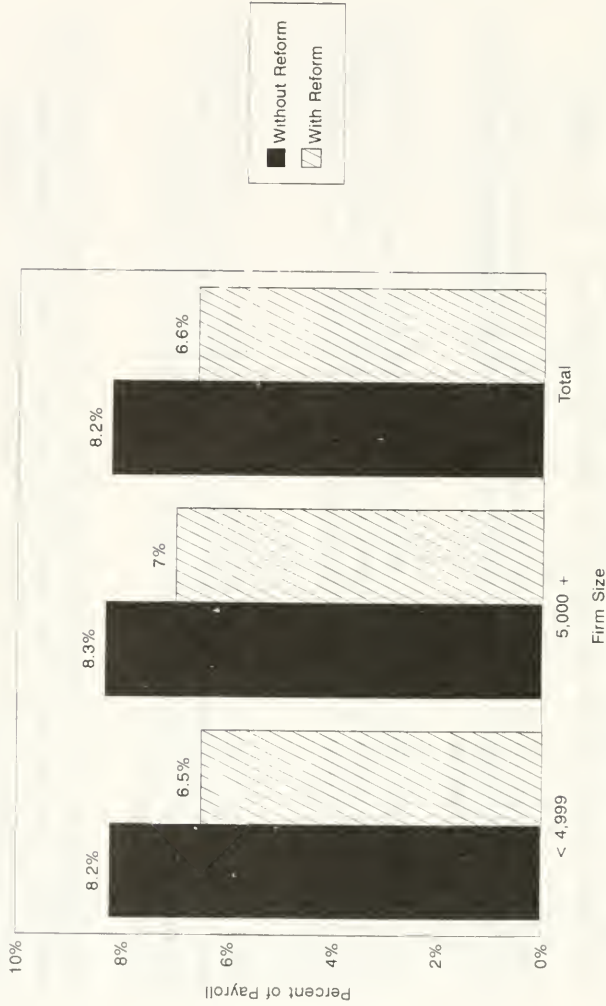
For Firms Currently Offering Insurance

For Firms with Greater or Less Than 5000 Employees: Year 2000

- Firms with more than 5000 employees are eligible to form corporate alliances. Employees of firms with less than 5000 employees will enroll in regional alliances.
- Under the Health Security Act, the average employer that currently offer insurance will pay less, per worker and as a percent of payroll, on health insurance premiums for their employees than would be the case without reform.
- Firms with less than 5000 employees that currently offer insurance will save \$621 per worker in the year 2000 alone. They will spend only 6.5 percent of total payroll on employees' health insurance premiums. [Charts III-G and III-H]
- Firms with more than 5000 employees that currently offer insurance will save \$551 per worker in the year 2000 alone. They will spend only 7.0 percent of total payroll on employees' health insurance premiums. [Charts III-G and III-H]

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

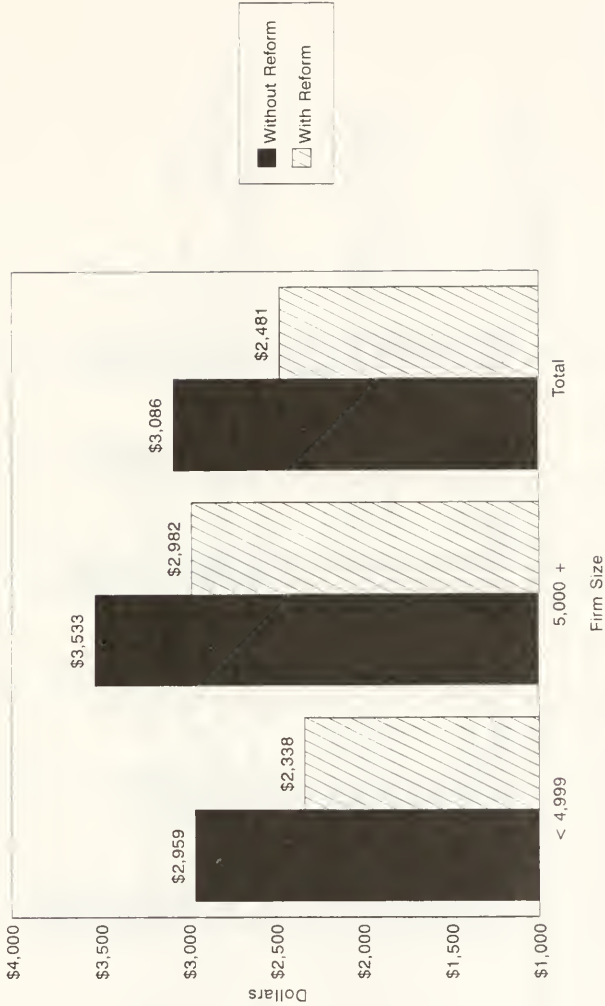
Average Annual Percent of Payroll for Firms Currently Offering Insurance
For Firms with Greater or Less Than 5,000 Employees: Year 2000



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Premiums per Worker for Firms Currently Offering Insurance
For Firms with Greater or Less Than 5,000 Employees: Year 2000



SOURCE HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts includes premiums paid by public and private employers for covered services in corporate and regional alliances.

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT
For Firms Currently Offering Insurance
By Firm Size: Year 2000

- On average, firms with fewer than 5000 employees that currently offer insurance will save, both as a percent of payroll and per worker, under the Health Security Act. [Charts III-I and III-J]
- Small firms with fewer than 25 workers will experience the largest savings as a percent of payroll under the Health Security Act. They will pay a full 2.6 percentage points less of their payroll - \$771 per worker - on premiums after reform. [Charts III-I and III-J]

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Percent of Payroll for Firms Currently Offering Insurance

By Firm Size: Year 2000

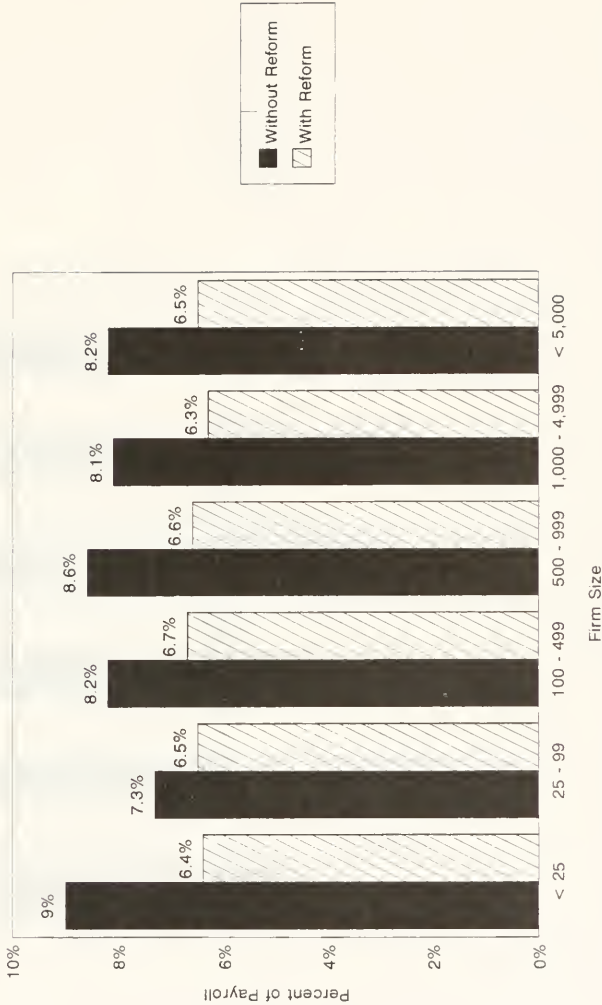


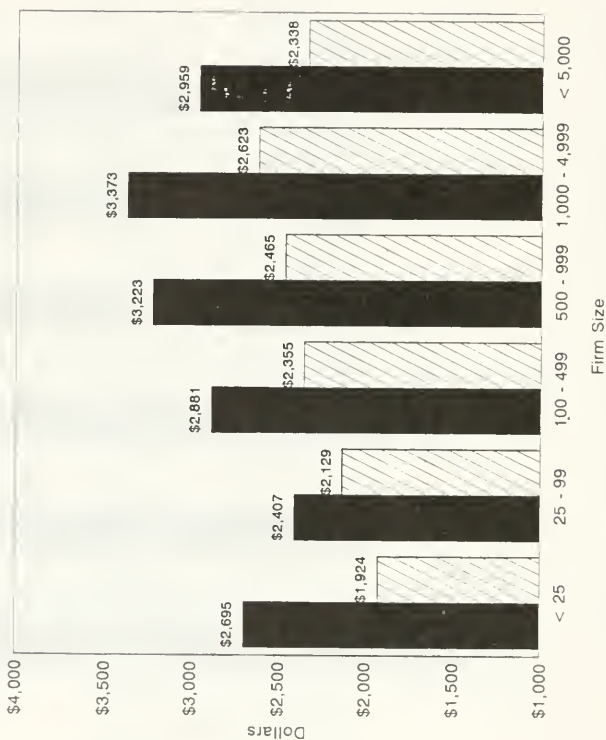
Chart III - I

SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premiums paid by public and private employers for covered services in corporate and regional alliances.

EMPLOYERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Premiums per Worker for Firms Currently Offering Insurance

By Firm Size: Year 2000



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts includes premiums paid by public and private employers for covered services in corporate and regional alliances.

IMPACT ON WORKERS AND FAMILIES

WORKERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT: 1994 - 2000

- Absent comprehensive reform, workers' premium payments would rise, on average, from 1.4 percent of payroll in 1994 to 1.7 percent in 2000. [Chart IV-A] By the year 2000, workers would contribute an average of \$600 each year for their share of their premiums. [Chart IV-B]
- As states phase in universal coverage under the Health Security Act, workers' premium payments will fall from 1.5 percent of payroll in 1996 to 1.2 percent in the year 2000. [Chart IV-A] By the year 2000, workers will contribute an average of \$437 per year for their share of their premiums -- 27 percent less than if there were no comprehensive reform. [Chart IV-B]
- Thus, under the Health Security Act, workers' premium payments will be 0.5 percentage points less of total payroll costs in the year 2000. [Chart IV-A]

WORKERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Percent of Payroll: 1994 - 2000

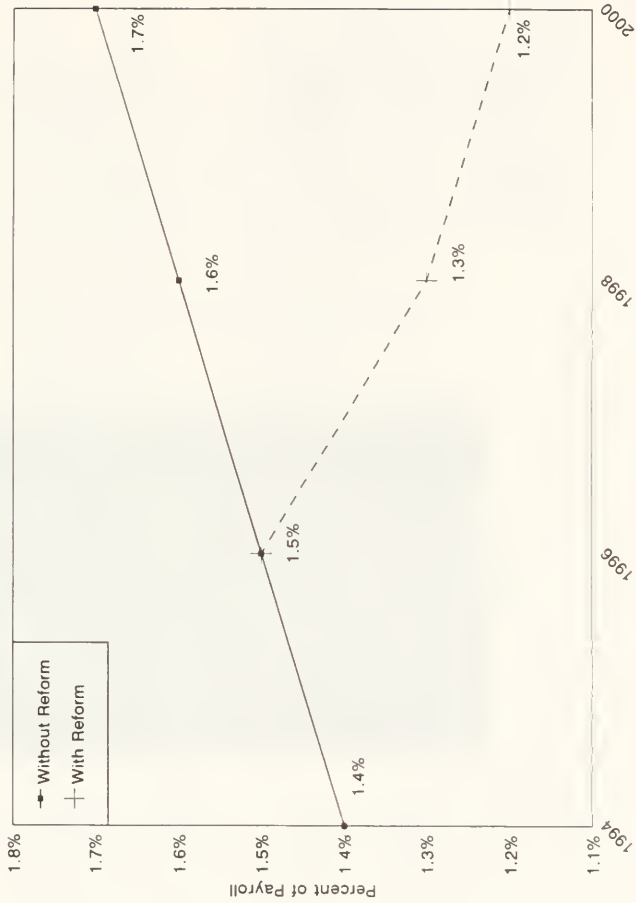


Chart IV-A

SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts

WORKERS' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Premiums per Worker: Year 2000

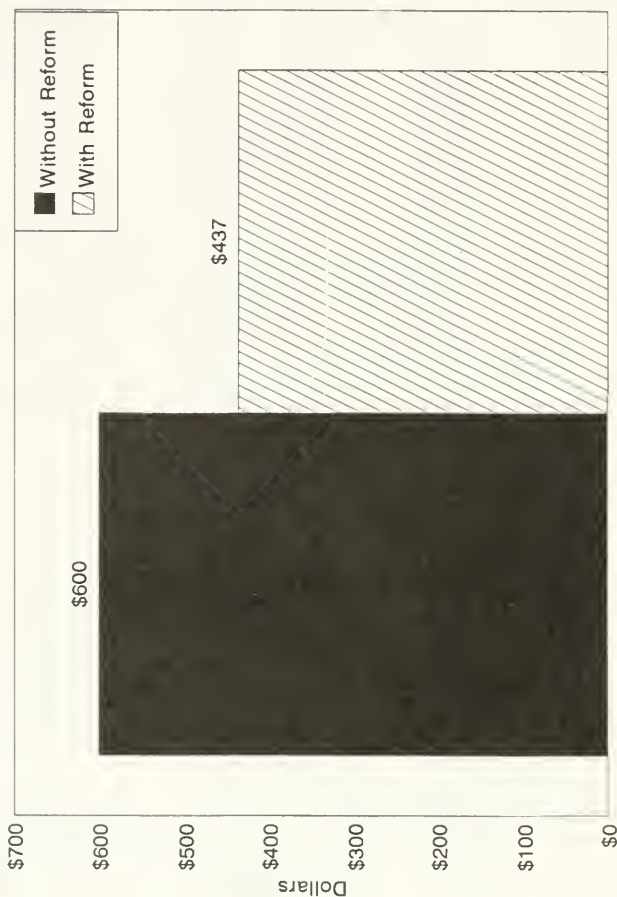


Chart IV-B

SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts.

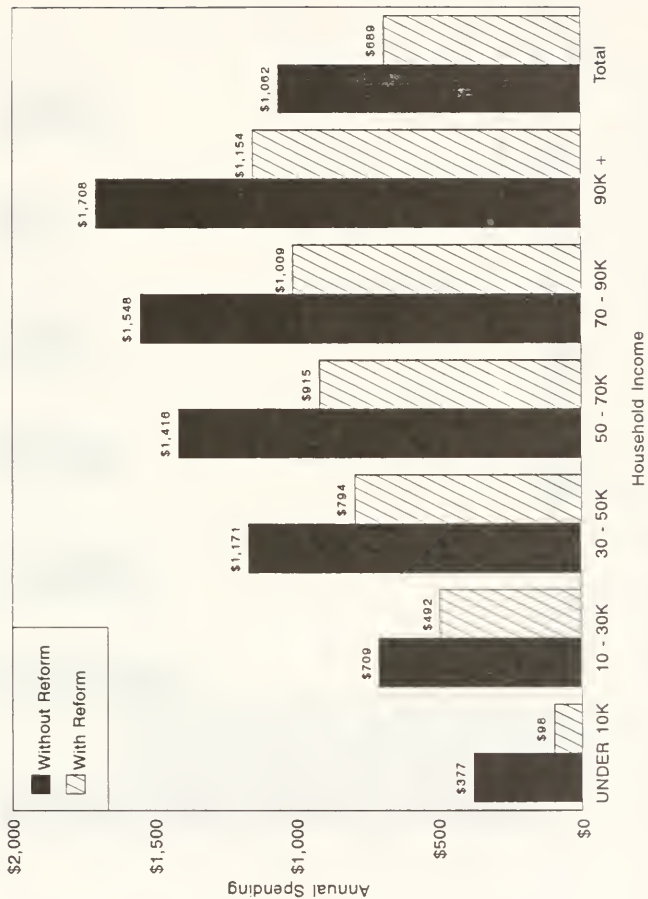
FAMILIES' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT:
Year 2000

- Absent comprehensive reform, families' average annual spending in the year 2000 on health insurance premiums would be \$373 higher than under the Health Security Act (\$1062 versus \$689, respectively). [Chart IV-C] This translates to their spending 2.3 percent of income on premiums without comprehensive reform, as opposed to 1.5 percent under the Health Security Act. [Chart IV-D]
- Families with annual incomes between \$30,000 and \$50,000 would spend an average of \$377 more for premiums in the year 2000 if there is no comprehensive reform than they would under the Health Security Act (\$1171 versus \$794, respectively). [Chart IV-C] This translates to their spending 3.1 percent of income on premiums without comprehensive reform, as opposed to 2.1 percent under the Health Security Act. [Chart IV-D]

- All families, regardless of income, will save money on premium payments in the year 2000 under the Health Security Act. [Chart IV-E]
- On average, families with annual incomes between \$30,000 and \$50,000 will spend 1.0 percent of income less on health care in 2000 under the Health Security Act. [Chart IV-E, Chart IV-C]
- On average, the Health Security Act will save families 35 percent of their premium costs in the year 2000. Families with annual incomes between \$30,000 and \$50,000 will save 32 percent. [Chart IV-C]

FAMILIES' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Average Annual Premium Spending: Year 2000



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts

FAMILIES' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT Average Annual Premium Spending as a Percent of Income: Year 2000

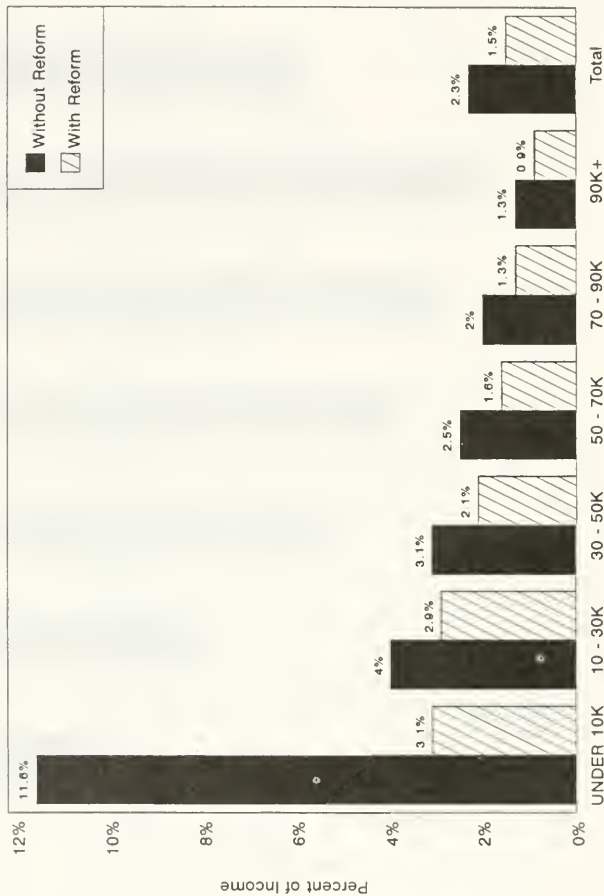


Chart IV-D

SOURCE HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts.

FAMILIES' PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT Average Annual Savings on Premium Spending as a Percent of Income By Income Category: Year 2000

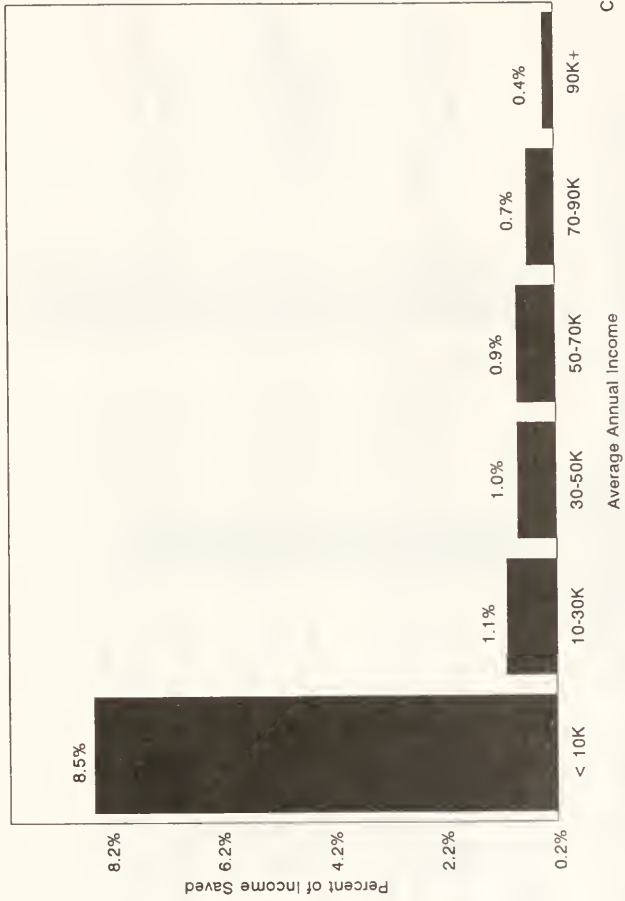


Chart IV-E

SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts

FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

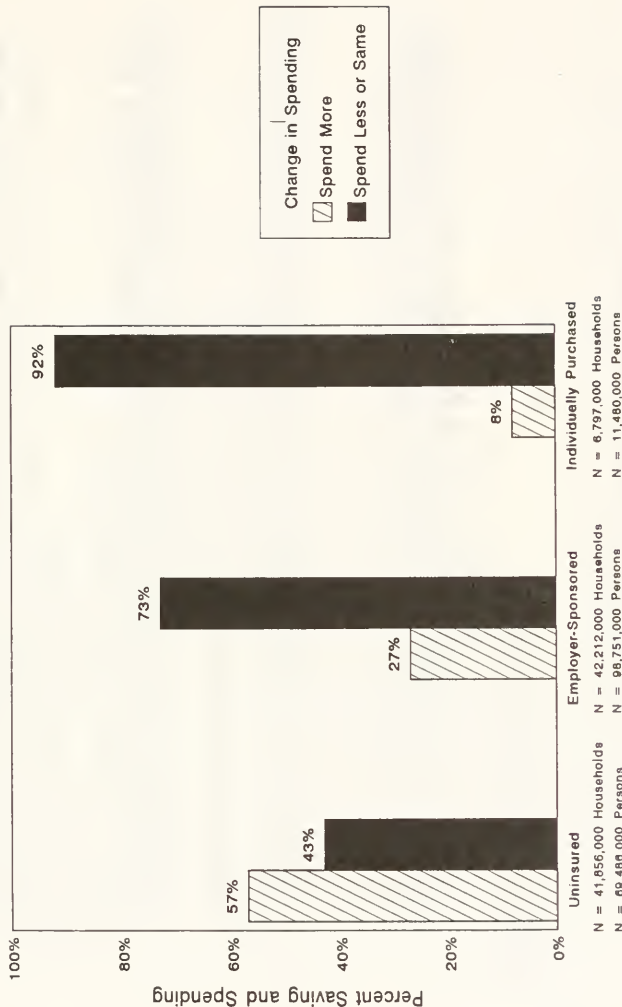
Year 2000

In the year 2000, under the Health Security Act:

- Of those families which are currently uninsured at least part of the year, 43 percent will spend the same or less for health care than they would if there were no comprehensive reform. [Chart IV-F]
- Of those families which currently have employer-sponsored insurance, 73 percent will spend the same or less for health care than they would if there were no comprehensive reform. [Chart IV-F]
- Of those families which currently purchase their insurance individually, 92 percent will spend the same or less for health care than they would if there were no comprehensive reform. [Chart IV-F]

FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

Change in Health Care Spending: Year 2000



SOURCE: HHS and Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premium and out-of-pocket spending in regional alliances. Uninsured includes 31.6 million persons uninsured part-year.

Chart IV-F

FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT By Current Insurance Type: Year 2000

Under the Health Security Act:

Employer-Sponsored Insurance

- 38 percent of all families which currently have employer-sponsored insurance will experience savings of up to \$1,000 in overall health care spending (premiums and out-of-pocket expenditures) in the year 2000. [Chart IV-H]
- 30 percent of all families which currently have employer-sponsored insurance will experience savings of more than \$1,000 in overall health care spending in the year 2000. [Chart IV-H]
- On **average**, families which experience savings in overall health care spending will enjoy a **decrease of \$109 per month** (\$1,309 for the year) in the year 2000. [Chart IV-G]
- 5 percent of all families which currently have employer-sponsored insurance will experience no change in overall health care spending (premiums and out-of-pocket expenditures) in 2000. [Chart IV-H]

- Families which will be spending more on overall health care expenditures will spend on average an additional \$31 per month (\$367 for the year) in the year 2000. [Chart IV-G]

Individually Purchased Insurance

- The vast majority (85.9 percent) of families which currently purchase health insurance individually will experience savings of more than \$1,000 on overall health care spending (premiums and out-of-pocket expenditures) in 2000. [Chart IV-I]
- On **average**, families which experience savings in overall health care spending will enjoy a **decrease of \$375 per month** (\$4,501 for the year) in the year 2000. [Chart IV-G]
- Families which will be spending more on overall health care expenditures will be spending an average of an additional \$75 per month (\$903 for the year) in 2000. [Chart IV-G]

Currently Uninsured

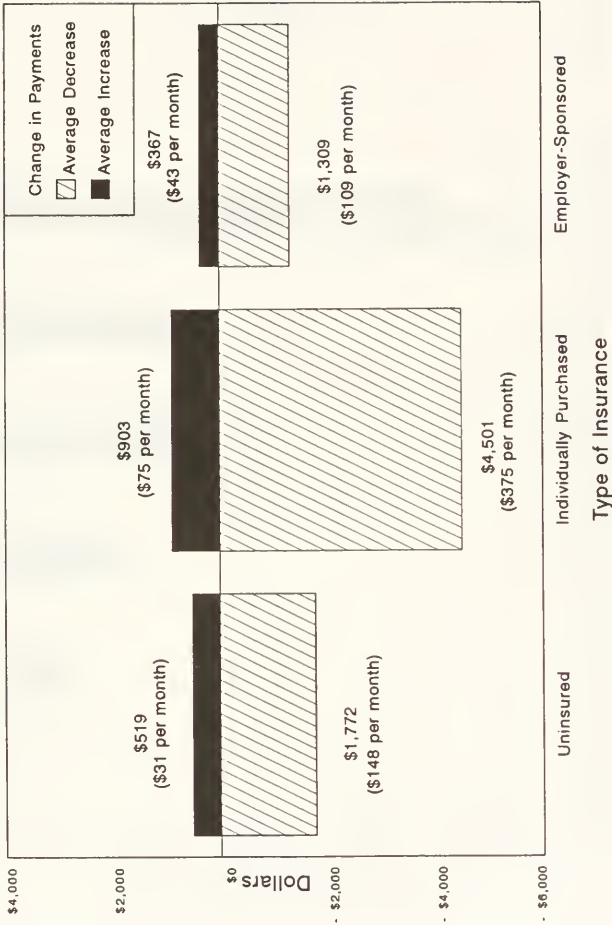
- 28 percent of all families which are currently uninsured at least part of the year will experience some savings in overall health care

spending in the year 2000, due largely to reductions in high out-of-pocket expenditures. The **average decrease** will be **\$148 per month** (\$1,772 for the year) in 2000. [Charts IV-G and IV-J]

- 15 percent of all families which are currently uninsured at least part of the year will experience no change in overall health care spending in 2000. [Chart IV-J]
- Families which will be spending more on overall health care expenditures will be spending an average of an additional \$43 per month (\$519 for the year) in 2000. [Chart IV-G]

FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

Average Annual Saving and Spending by Current Insurance Type: Year 2000



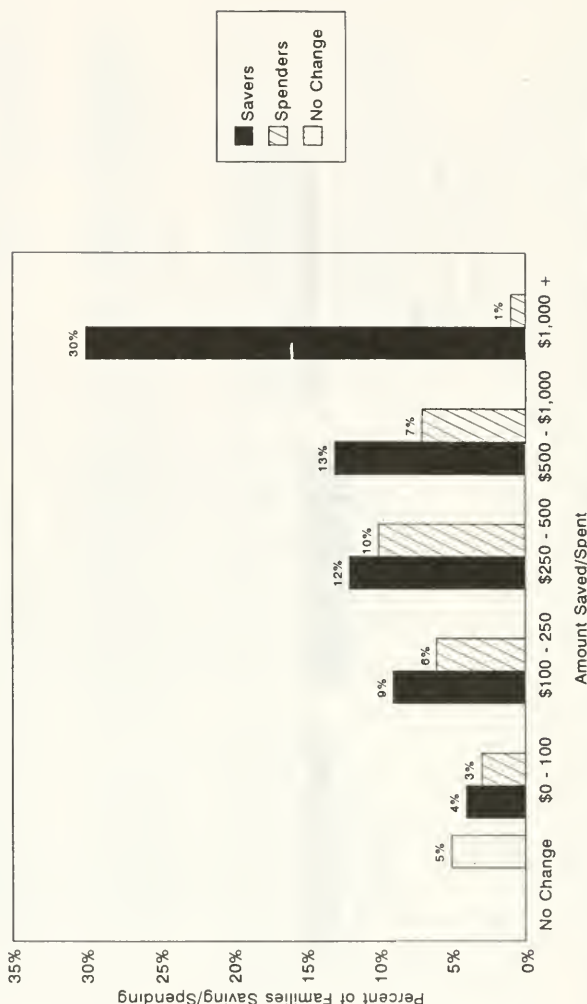
SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premium and out-of-pocket spending in regional alliances. Uninsured includes 31.6 million persons uninsured part-year.

FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

Average Annual Percent Change in Spending

Families which Currently have Employer-Sponsored Insurance: Year 2000

N = 42,212,000 Families



SOURCE: HHS and The Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts. Includes premium and out-of-pocket expenditures for those in regional alliances. Totals may not add to 100% due to rounding.

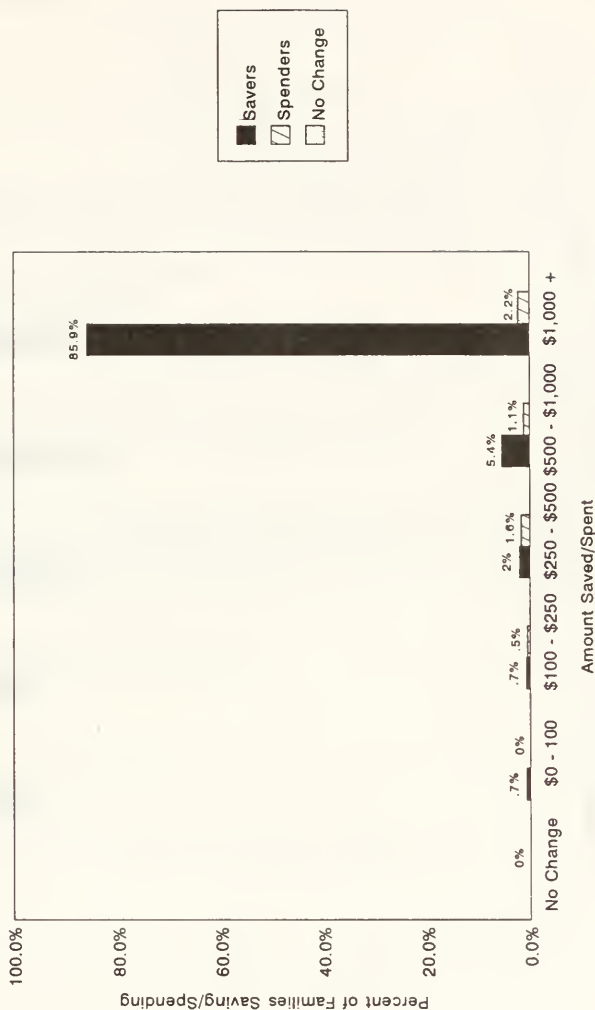
Chart IV-H

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FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

Average Annual Percent Change in Spending
Families which Currently Purchase Insurance Individually: Year 2000

N = 6,797,000 Families

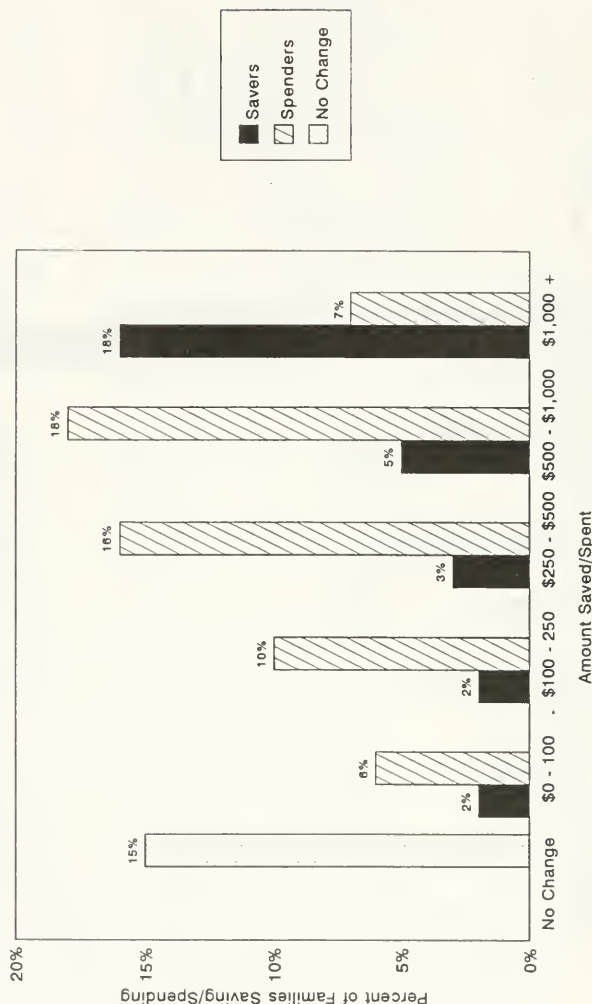


SOURCE: Center for Intramural Research, AHCPR.
Includes premium and out-of-pocket expenditures for those in regional alliances
Totals may not add to 100% due to rounding

FAMILIES' EXPENDITURES UNDER THE HEALTH SECURITY ACT

Average Annual Percent Change in Spending
Families which are Currently Uninsured: Year 2000

N = 41,856,000 Families



SOURCE: HHS and The Urban Institute's TBM2 Model, benchmarked to HCFA's National Health Accounts. Includes premium and out-of-pocket expenditures for those in regional alliances. Totals may not = 100% due to rounding. Uninsured includes 31.6 million persons uninsured part-year.

THE COSTS OF FAILING TO REFORM HEALTH CARE

I. HEALTH CARE SPENDING PER WORKING AMERICAN WILL BE OVER \$7,000 IN 1994.

Working Americans will, on average, pay \$1,864 directly for health care in 1994. Their employers will pay \$3,409 for health insurance and other medical payments. Federal, State, and Local taxes for health care will total \$2,149.

II. WITHOUT HEALTH CARE REFORM, AMERICAN WORKERS' WAGES WILL CONTINUE TO STAGNATE.

The rapid growth in health care costs relative to the rest of the economy may have depressed wages by up to \$1,000 since 1975. If current trends continue without reform, real wages may be further reduced by over \$600 by the end of the decade.

III. THE LACK OF SECURITY AFFECTS EMPLOYMENT

Many individuals are afraid to leave their current job, for fear that they will be unable to obtain insurance on a future job. Some individuals do not work for small businesses or do not become self-employed because of the high cost of health insurance for these groups. Many individuals on welfare would like to work but cannot take a job without losing Medicaid benefits.

The Costs of Failing to Reform Health Care

by

Laura D'Andrea Tyson

Chair, Council of Economic Advisers

October 6, 1993

I. Effects on Individuals

Our health care system is costly and does not provide security to people. If a person loses a job, changes jobs, or gets sick, there is no guarantee of health coverage.

A. Health care spending per working American will be over \$7,000 in 1994. This total includes (Chart 1):

- i. Out-of-pocket spending and the worker's share of the insurance premium (\$1,864 in 1994).
- ii. Employer-paid premiums (\$3,163).
- iii. Employer-paid workers' compensation, disability insurance, and industrial insurance to their workers (\$246).
- iv. Payroll taxes to pay for Medicare (\$926).
- v. Other taxes, fees, and payments (Medicare and Medicaid predominantly) paid to the Federal government (\$654).
- vi. Taxes, fees, and payments (Medicaid and state employees predominantly) to state and local governments (\$569).

If we do not have health care reform soon, health care spending per working American will rise to \$12,386 by the year 2000, or 25 percent of compensation.

B. The current insurance system does not provide true security.

- i. Insurers focus on risk selection rather than pooling groups of people.
 - Almost 40 percent of insurers exclude pre-existing conditions from their coverage of newly insured people.
 - Insurers also price by the experience of the group. This means that people cannot get one of the most important types of insurance coverage they want: the right not to have to pay more if they get sick.
 - Insurers "red line" or refuse to cover specific industries that they find to be hazardous, including many small businesses.
- ii. The number of people who are uninsured is high and rising.

- Three-quarters of the uninsured are in working families. Thirty-two percent of the uninsured are in families with at least one full-time year-round worker.
- C. Fear of losing coverage causes people to keep jobs they would like to leave or to stay on welfare.
- i. Up to 30 percent of employees report that they are afraid to leave their job for fear of losing continuous health insurance coverage. This reduction in mobility, or "job lock," can be a major impediment to the efficiency of the economy.
 - ii. One of the most important reasons people do not leave AFDC is the fear of losing health care coverage for themselves and their children. This "welfare lock" traps people into public programs and raises government costs.
 - iii. Health insurance creates a substantial barrier to many people choosing to become self-employed or to start a small firm. Self-employed people face higher administrative costs than people in large firms for health insurance coverage. In addition, because groups are experience rated, even self-employed people in good health risk having high premiums in future years if they become sick.
- D. Currently insured people are paying for the costs incurred by the uninsured.
- Current estimates suggest that about \$25 billion of uncompensated care is paid for by the insured. It is estimated that, in 1994, there will be about \$217 billion of business and household spending on health insurance. Providing health insurance for all Americans will allow for savings that exceed 10 percent of existing insurance spending.

II. The Total Costs of Health Care are High and Rising.

A. Current and Projected Health Care Costs

- i. In 1992, the United States devoted 14 percent of GDP to health care. In 1980, the share was 9 percent. No other country in the world spends more than 10 percent of GDP on health care. Without health care reform, it is estimated that health care spending will consume 18 percent of GDP in the United States by the year 2000.
- ii. The United States spends as much on health care as it does on fuel oil, electricity, natural gas, other household operations, oil and gasoline, transportation (including all new and used car purchases), furniture, and other household equipment combined.
- iii. Over forty percent of the growth of real per capita GDP between 1993 and 1996 will be accounted for by health care spending. While some of this growth is

warranted, this unusually high rate crowds out other items of consumption.

iv. Health care cost growth will continue to outpace growth in other segments of the economy.

- Federal Medicaid growth is expected to be over 16 percent in 1994, and to decline to only 12 percent in the rest of the decade. Medicare growth will be between 9 and 11 percent and private health care costs will grow at between 7 and 8 percent for the rest of the decade. Growth in the rest of the economy is expected to be between 4 and 6 percent.

B. The high cost of health care is driven by several market failures.

There are numerous instances where the current system encourages wasteful and inefficient medical practices.

i. There is a lack of price competition in the market for insurance, because many individuals do not have a choice of health care plans.

- Only 29 percent of companies with fewer than 500 employees offer any choice of plans.

ii. Administrative costs in health insurance are extremely high, in part because there is little or no coordination across insurers in the forms they require or their reimbursement systems.

- Over 5 percent of health care expenditures (\$45 billion in 1992) went for administrative expenses. This exceeds the total amount spent on all public health service programs.

D. The health care system has a great deal of waste. The current system of reimbursement encourages providers to over-utilize tests and procedures.

i. Research suggests that up to one-half of some procedures that are performed may be either inappropriate or unnecessary. For example, it is estimated that the United States spent \$1 billion on unnecessary Cesarean sections in 1987 alone.

ii. Fraud and abuse may account for about 10 percent of U.S. health care costs.

III. The Cost to Business

- A. Businesses pay for health care through premium contributions and other programs such as workers compensation.
 - i. Real business spending on health care has risen from \$774 per employee (in \$1992) in 1970 to \$2,345 in 1992, a 200 percent increase.
 - ii. Real workers' compensation per employee has more than doubled since 1970, rising from \$149 (in \$1987) in 1970 to \$326 in 1992. Health care costs are the fastest growing component of workers' compensation.
- B. Small firms are particularly hurt by the current system, because many do not have access to affordable health care.
 - i. Small firms face administrative loads of up to 40 percent, compared to about 5 percent in large firms with 10,000 or more employees.
 - ii. Because of experience rating, many small firms must pay exorbitant amounts for insurance or are unable to get insurance at all.
 - iii. Small firms often cannot afford to provide any choice of health care plan to their employees.
- C. There is cost shifting from government health care programs and people who are privately insured to the uninsured.
 - Currently, Medicaid pays providers at about 82 percent of costs, and Medicare pays at 88 percent of costs. The uninsured pay at 20 percent of costs. The resulting cost shifting (\$26 billion of hospital costs alone) results in higher premiums in the private sector (Chart 2).

IV. The cost to the Government

Our health care system is a growing burden on the government and leads to increased deficits.

- A. Governments are responsible for 44 percent of health care spending.
 - At the Federal level, most of this spending is for Medicare and Medicaid. State and local spending is predominantly for Medicaid, and for health care for state and local government workers.

B. Rising health costs crowd out other government spending and contribute to the deficit.

- i. Health care spending accounts for 17 percent of Federal spending. Under current projections, that share is expected to rise to over 20 percent in the next five years. As health care continues to consume a larger share of the budget, Federal spending on education, training, employment and social services will actually decline as a share of total Federal spending over this period. The rate of return to many government investments — such as education — is very high.

C. Health care will absorb much of government spending in the next several years.

- Almost two-thirds of the growth in federal spending between 1993 and 1996 will be accounted for by health care spending.

V. The Cost to Families

A. The bottom line for workers is that they ultimately pay for most of health care spending, either out-of-pocket or indirectly, through higher taxes and lower wages.

- Empirical research suggests that the dominant response of businesses to higher health insurance costs has been to lower the wages they pay their employees. Similarly, the taxes required to pay for government health spending are born to some extent by workers in the form of lower wages. One of the reasons that real wages have barely grown for the past 20 years is the increased costs of health care for businesses.

B. Without reform, wages of American workers will continue to lag.

- If employer contributions to health insurance remained constant at their 1992 share of compensation through the rest of the decade, and employers passed all of these savings on to workers, real wages per worker would be \$655 higher in 2000 than they are otherwise projected to be. If they had remained at their 1975 share, real wages would have been \$1,034 higher in 1992 than they actually were (Chart 3).

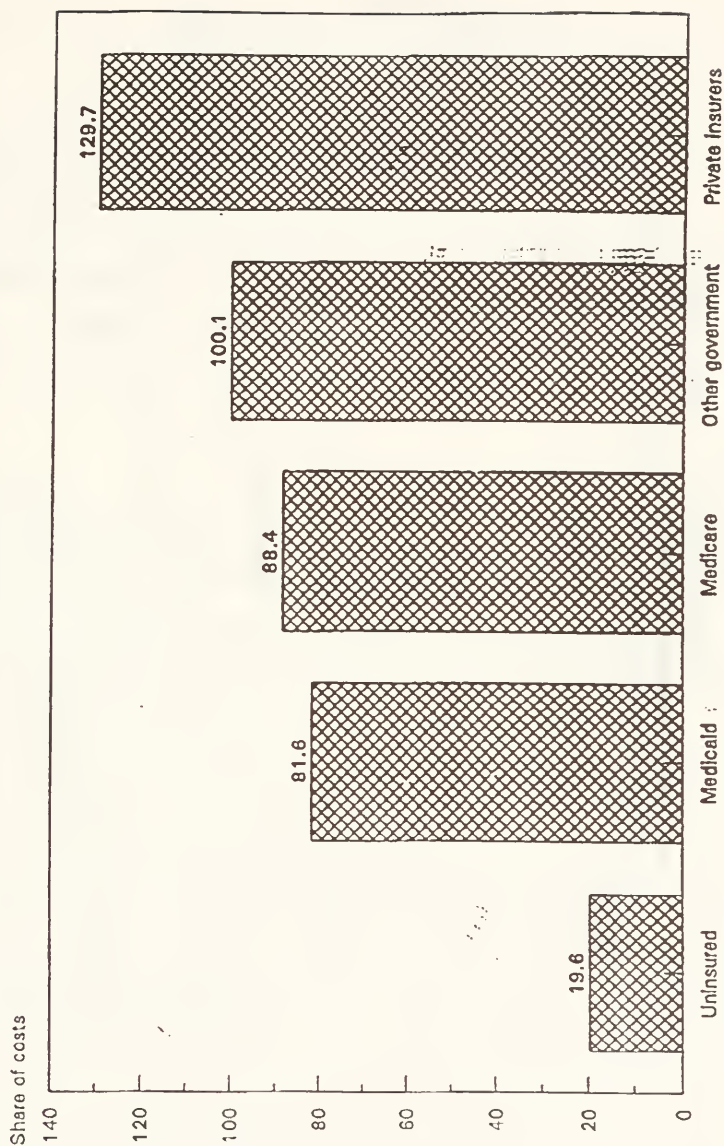
Cost to Families

Average insured worker's health spending without health reform

	1994	Health Bill as % of Compensation	2000	Health Bill as % of Compensation
average compensation per worker:	\$36,289		\$50,334	
average insured worker's health bill				
Health Insurance	\$7,423	20.45%	\$12,386	24.61%
Employer's share of premium	\$4,132	11.38%	\$8,686	19.70%
Individual's share of premium	\$3,163	8.71%	\$5,278	10.49%
Medicare payroll tax	\$969	2.67%	\$1,617	3.21%
Workers' comp/disability/industrial inplant	\$248	2.55%	\$1,646	3.07%
Out-of-pocket	\$246	0.68%	\$411	0.82%
Other spending at health facilities	\$782	2.16%	\$1,305	2.59%
Federal taxes, fees, & other payments	\$113	0.31%	\$168	0.37%
Federal employees' health premiums	\$654	1.80%	\$1,092	2.17%
Federal contributions to Medicare HI	\$53	0.15%	\$88	0.18%
Medicare (general revenue)	\$11	0.03%	\$19	0.04%
Medicaid	\$169	0.47%	\$283	0.56%
Other federal health programs	\$246	0.68%	\$411	0.82%
State & local taxes, fees, & other payments	\$174	0.48%	\$290	0.58%
State/local employees' health premiums	\$689	1.87%	\$950	1.89%
State/local contributions to Medicare HI	\$149	0.41%	\$248	0.49%
Medicaid	\$24	0.06%	\$39	0.08%
Hospital subsidies	\$186	0.51%	\$310	0.62%
Other programs	\$81	0.22%	\$135	0.27%
	\$130	0.36%	\$218	0.43%

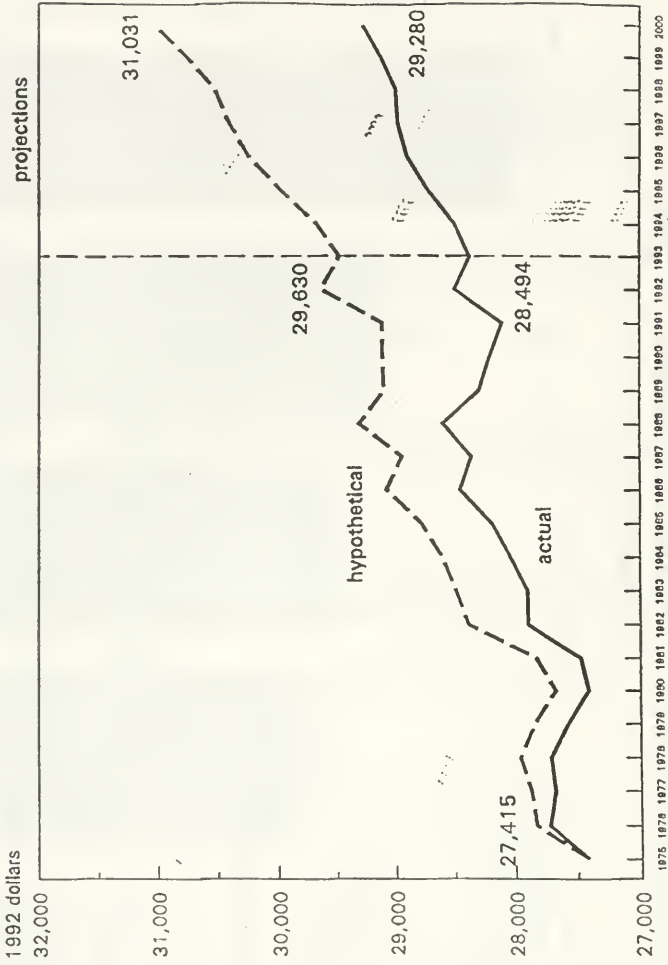
Source: Office of Health Policy, ASPH. HHS analysis using Health Care Financing Administration's Urban Institutes and
and Department of Commerce, Bureau of Economic Analysis data.

Privately Insured People Pay for Inadequate Reimbursement in the Public Sector and for the Uninsured



Real Cash Wages per Full-Time Employee

Real wages would have been higher if employer contributions to health insurance as a share of total compensation had remained at their 1975 share.



Note: Dollars are deflated using the GDP deflator for consumption.

Sources: Department of Commerce, Health Care Financing Administration

Methodological Description of Health Care Reform Premium and Discount Estimates

Contributions to this paper were made by:

- Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation
- The Office of Management and Budget
- Health Care Financing Administration's Office of the Actuary
- Agency for Health Care Policy and Research
- The Urban Institute's Center for Income and Benefits Policy

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Appendix A: Example of the Application of an Induction Factor to a Change in Insurance Status

I. Background

Estimates of premium costs, national health spending, and government program costs under health care reform have been necessary in the decisions leading to a health care reform bill. During the basic policy development process, exploration of alternative policies required estimates of the cost impacts of each possible variation. Specific areas included analyses of premium caps, the impacts on businesses of required employer payments, the effects on households of required purchase of coverage, and the budgetary effects of the discount schedules.

The development of estimates of this type is obviously a complex task. Given that no single authoritative data set exists which captures all spending for all services through all sources of funding, numerous data sources were used in this process. Federal surveys, especially the National Medical Expenditure Survey (1987), offer the best characterizations of national spending. The National Health Accounts generated by the Health Care Financing Administration (HCFA) summarize the best available data on total national spending by type of service and source of fund. Producing estimated spending under health reform, however, requires developing a comprehensive baseline summary for literally hundreds of affected sub-populations, and then estimating the future spending patterns associated with the reform.

Estimates of future costs of reform are primarily derived through modeling transfers of current spending among the various channels of payment. Estimating the impacts of changing primary payers is relatively straightforward, given a baseline of national health spending. More difficult is estimating the net impacts of fee upgrades and paying for uncompensated care, since reimbursement levels will be set to achieve some amount of recapture of these increased outlays for current services. Also difficult is estimating the induced spending attributable to new or enriched insurance coverage. Estimates have been based upon experiences of government and private insurers as well as the results of academic studies of the demand for medical care.

Multiple data sources, methodologies, and models were needed to produce estimates of premiums, discounts, and the overall effects of reform options. Major contributors included the Health Care Financing Administration's (HCFA) Office of the Actuary (OAct), the Agency for Health Care Policy and Research (AHCPR), the Treasury Department, and other government agencies. Numerous consultants assisted in the process, with major modeling contributions provided by the Urban Institute. This paper provides an overview of the major models and their ways of estimating premiums, discounts, and overall health spending under health care reform.

II. Description of the Major Models

A. The Urban Institute's Transfer Income Model (TRIM2):

The Urban Institute has developed a microsimulation model called the Transfer Income Model (TRIM2). This model has been used to analyze the financing of national health care reform plans, and has particularly focused on the distributional effects of such proposals. TRIM2 is based upon the March 1992 Current Population Survey (CPS) and combines data from a number of other sources in order to provide a complete basis for assessing acute care health spending by the non-elderly in the U.S. population.¹ The complete model has been aged to 1994, and all results are presented in 1994 dollars. The following description of TRIM2 and its capabilities has been adapted from Zedlewski, Holahan, Blumberg, and Winterbottom (1993).

The TRIM2 model simulates the employer-based group health insurance system, nongroup or individually purchased health insurance, out-of-pocket spending, and the Medicaid program. The model assigns spending under these programs/systems at the individual and family levels and adjusts for regional variation in premium levels. It is then possible to assess the distributional effects of the financing of the current health care system. Detailed tax calculations allow the analysts to examine health spending on an after-tax basis and to calculate the after-tax value of employment-based health benefits. TRIM2 can also be used to simulate the distribution of health spending and health care financing burdens under alternative assumptions about how insurance would be provided and financed. Each component of the basic model is presented below.²

1. Employment-Based Group Health Insurance. TRIM2 examines reported insurance coverage for individuals and families on the CPS to determine the number of family members who share coverage under an employment-based policy.³ The model assigns an employment-based health insurance premium, including the shares paid by the employer and the employee, to each covered worker based on two 1989 private, employer-based surveys (from the Health Insurance Association of America and Foster-Higgins) and federal health insurance plan documents. These private surveys represent firms of different sizes, in all major industries (including state and local government), and in all regions of the country. Federal health insurance plan documents include information about premiums for single and family coverage and how these premiums are distributed between the employer and worker. TRIM2 statistically matches workers to health plans based on variables that the employer insurance

¹Historically, TRIM2 has been used to analyze current and alternative tax and transfer programs. See National Research Council (1991) and Lewis and Michel (1990) for a more complete description of the properties of this model and its recent applications.

²Giannarelli (1992) describes the full TRIM2 model.

³Zedlewski (1991) describes this model in more detail.

plans and workers on the CPS have in common. These include the type of coverage (single or family), location, industry, the size of firm, and whether or not the worker has to pay part of the insurance premium.

2. Private, Nongroup Health Insurance. TRIM2 estimates premiums for the families and individuals on the CPS who report insurance coverage through private, nongroup, health insurance policies. It does this by matching these people with plan data collected from Blue Cross and Blue Shield Plan offices across the U.S. Plan documents included premiums for typical health insurance plans covering single individuals, families, and dual (adult and child) insurance units in each state. The method does not, however, capture differences due to families' insurance preferences or income levels. For example, if low (or high) income families reporting private, nongroup health insurance are more likely to purchase catastrophic policies, the model will overstate their premiums. Conversely, the model will understate premiums for families who prefer broader coverage than that included in the prototypical plan.

3. Medicaid. TRIM2 uses detailed sets of algorithms to replicate the rules of state Medicaid programs.⁴ These algorithms identify Medicaid eligibles as all persons who meet the states' categorical, asset, and income criteria in effect July 1991. The model has procedures for selecting Medicaid enrollees from those who are eligible. The second part of the model imputes the insurance value of Medicaid. Separate estimates are made for adults, children, and the disabled; estimates also vary by age, sex, race, urban or rural residence, reason for enrollment, and number of months in the program. The model uses Medicaid state expenditure data to adjust for differences among states in program generosity and the cost of health services.

4. Out-of-Pocket Spending. The model uses data from the Consumer Expenditures Survey to predict out-of-pocket spending (other than health insurance premiums) for families on the CPS.⁵ Separate equations were estimated for persons with private insurance coverage, Medicaid, and for those uninsured. The equations predict the incidence and levels of spending as a function of families' socioeconomic characteristics including region of residence, income, the age-sex distribution of family members, and the family head's marital status, education, race, and work status.

5. Income and Payroll Taxes. The model calculates family disposable income and estimates the amount of income and payroll taxes required to finance health care spending by

⁴See Holahan and Zedlewski (1989) for a full description of this model.

⁵See Wade (1991) for a full description of this model.

the federal government through the Medicaid and Medicare programs. Other federal taxes (such as corporate, estate, and excise taxes) are not included.⁶ The portion of Medicaid and Medicare spending that is financed through the federal personal income and payroll tax systems is calculated and can be allocated to families. The model can also calculate income and payroll taxes under the assumption that employer-paid health insurance premiums are taxable to estimate the tax value of this employee benefit.

6. Total Health Care Spending for the Nonelderly. The TRIM2 baseline distribution of direct spending from various sources accounts for most health spending for the nonelderly. The TRIM2 model excludes the institutionalized population. In addition, Medicare benefits for the nonelderly and military health benefits are excluded. Nevertheless, the model accounts for nearly all of the spending under systems that would be most affected by health care reform alternatives currently under debate.

7. Adjustments to TRIM2 Baseline Output. Two significant adjustments were made to the TRIM2 baseline health spending simulations at the request of the office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (DHHS). Both employer health insurance premiums and private nongroup health insurance premiums in TRIM2 were downwardly adjusted to reflect health care reform premiums estimated by the Office of the Actuary (OACT). The TRIM2 employer plan data include employer spending for dental care and a few other benefits that not fully covered by the reform package. Without this adjustment for differences in coverage, employer and family spending under reform as calculated in TRIM2 (using HCFA OACT premiums) would not be comparable to employer and family spending under the current system according to TRIM2. Thus, estimated changes in spending under reform compared to current spending would be distorted without reconciling the spending levels.

B. The Health Care Financing Administration's Special Policy Analysis Model (SPAM):

The Health Care Financing Administration's (HCFA) Special Policy Analysis Model (SPAM) database is also based upon the March 1992 Current Population Survey (CPS). The March 1992 CPS acts as the host file, with each person on it being statistically matched to a person on the 1987 National Medical Expenditure Survey (NMES). Health expenditures and utilization from the NMES person record are then linked to the CPS record, and the entire data set is controlled to be consistent with 1994 National Health Account data.

⁶However, the TRIM2 model does have the capacity to simulate excise tax payments on alcohol and cigarettes.

The parameters used in the linking the NMES file to the CPS were disability status (disabled or not), age and gender (male adult < 19, male adult 19-44, male adult 45-64, male adult 65+, female adult < 19, female adult 19-44, female adult 45-64, female adult 65+, dependent child < 19, and dependent child 19+), family income (family under 100% of poverty, family 100% to 185% of poverty, family at or above 185% of poverty), and insurance class of the person (employer sponsored insurance and Medicare, employer sponsored insurance and Medicaid, other employer sponsored insurance, Medicare and Medicaid and other private insurance, Medicare and Medicaid, Medicare only, Medicaid and other private insurance, Medicaid only, other insurance, and uninsured).

For a CPS person to be considered disabled, one of the following situations had to be true: (a) person was a veteran, collecting veteran's disability, (b) person collected over \$10,000 in workers compensation, (c) person had disability income, or (d) person was under 65 and had SSI income. For a NMES person to be considered disabled, one of the following had to be true: (a) person was a disabled veteran, (b) person didn't work due to disability/illness, or (c) person was without a job due to disability/illness.

The determination of adult vs. child was made from "insurance families," which were appended to both the CPS and NMES files. These families were created using standard insurance industry definitions. Within an insurance family there can be one or two adults (single or married couple), and any number of dependent children (or none).

The insurance classifications were hierarchical, and made on the person level using the appropriate variables on both the CPS and NMES. NMES insurance classifications were converted from round data⁷ to "ever insured" data (for example, if a person had Medicare in one of the rounds of the NMES survey, they were coded as having Medicare). Poverty classifications were calculated by adding income of all insurance family members together and comparing it to the appropriate poverty standard for the year in question (1991 for the CPS and 1987 for NMES), for the appropriate family size.

Once each CPS person was linked to a NMES record, expenditure data by service (hospital inpatient, hospital outpatient, etc.) and source of payment (out-of-pocket, private insurance, Medicare, Medicaid, etc.) were attached. This file was then aged to 1994 through two steps. First, the 1992 CPS population was weighted to sum to the 1994 Social Security Administration (SSA) non-institutionalized population (about 20 million more than Census estimates). This was done by age (20 age groups), gender and marital status (single, married, divorced, and widowed).

⁷NMES-2, described more fully in the following section, involves 4 surveys of each family over a period of 16 months. Each of the 4 interview sessions is referred to here as a "round."

Second, the total national health expenditures by this SSA-weighted CPS population (the SPAM population) were then "benchmarked" by service category, channel of payment, and age category to the aggregate totals in the projected 1994 National Health Accounts. There are 13 service categories: hospital inpatient, hospital outpatient, hospital emergency room, physician inpatient, physician outpatient, physician emergency room, physician office visit, other professionals, prescription drugs, home health care, dental, vision, and other durable medical equipment. There are eight channels of payment: private health insurance, out of pocket, Medicare, Medicaid, other federal, other state and local, workers compensation, and other private. There are three age categories: under 19, 19 to 64, 65 years and over.

An example of how this benchmarking worked is as follows. Suppose the ratio of current SPAM out-of-pocket inpatient hospital spending for persons under age 19 to NHA-consistent spending for the same cell is 0.9. Then each SPAM person's inpatient hospital spending total is multiplied by 1.11. The only divergence from this logic was that out-of-pocket spending for the uninsured was controlled separately from out-of-pocket spending for the insured population (which was thought to have risen at a rate closer to the rate of inflation in insurance).

C. The Agency for Health Care Policy and Research's Simulation Model (AHSIM):

AHSIM is based on AHCPR's 1987 National Medical Expenditure Survey (NMES-2), which is the most recent national effort to collect comprehensive, person-level profiles of health care use, spending, and insurance coverage. AHSIM currently is designed only to analyze the nonelderly (under 65), noninstitutionalized civilian population residing in the United States. Although the NMES-2 data were collected in 1987, demographic variables have been aged forward by reweighting individual records. New weights take into account changes in the distribution of the population by age, race, sex, insurance status, and poverty status observed between the November 1987 and March 1992 Current Population Surveys. Additional demographic aging is based on Census projections of the population by age, race, and sex beyond 1992. Real growth in service-specific health expenditures and insurance premiums have been incorporated through adjustments based on the appropriate rates of changes in HCFA's National Health Accounts and its projections.

AHSIM draws primarily on the NMES-2 Household Survey and its two derivative components, the Health Insurance Plan Survey (HIPS) and the Medical Provider Survey. The Household Survey sample is representative of the civilian noninstitutionalized population of the United States in 1987. Each family in the Household Survey was interviewed four times ("rounds") over a period of 16 months to obtain information about the family's health and health care during calendar year 1987. Roughly 35,000 individuals and 14,000 households completed all rounds of data collection. The Medical Provider Survey obtained information

directly from the physicians, hospitals, and other providers used by a portion of the household sample. These data were used to edit and supplement household survey data describing use of and spending on health services. HIPS data were collected from employers, unions, and insurers and include premiums paid by all sources and specific provisions of baseline private insurance coverage. They also provide information about the organizations offering insurance coverage and include in the case of employers, firm and establishment size, industry, and location.

Other data sources were incorporated when needed for specific purposes. For example, survey data from the Health Insurance Association of America were used to project market shares for fee-for-service, HMO, and preferred provider health plans by region. Annual survey data from the American Hospital Association were used to determine the allocation of hospital spending between inpatient and outpatient services and to identify local areas in which at least one HMO is operating. County Business Patterns data were used to impute average payroll for employers, using a statistical match based on industry, location, and firm size. The Internal Revenue Service (IRS) Statistics of Income (SOI) data were used to expand NMES-2 income data and to calibrate the AHSIM tax module. Further details of the basic AHSIM Model are presented below.

1. Employment-Based Group Health Insurance. AHSIM does not model employers, only households and individuals. HIPS and Household Survey data measured the scope of employment-based insurance in 1987, as well as the allocation of premiums among employers, employees, and other sources (primarily unions). AHSIM assumes that any changes in the pattern of availability, benefits, premiums, or other plan provisions between 1987 and 1994 are controlled for in the aging process, using CPS and HCFA aggregate data.

2. Private, Nongroup Health Insurance. AHSIM handles people with private, nongroup insurance in the same way as it does those with employment-based insurance. This means, for example, that a tendency for people with systematically higher medical expenditures to purchase private, nongroup health insurance will be captured in the model.

3. Medicaid. NMES-2 measured Medicaid program participation directly. Since 1987, however, Medicaid eligibility has been expanded to include low-income pregnant women and children who are not otherwise categorically eligible. This Medicaid expansion was incorporated into the AHSIM model by identifying household survey respondents who would have become eligible for Medicaid benefits by 1994 and modifying their baseline insurance status accordingly. Baseline health spending for new Medicaid recipients was also modified to reflect the effect of a changes insurance status, using the same methods that were used to project estimates for the uninsured after reform.

4. Out-of-Pocket Spending. NMES-2 directly measures baseline out-of-pocket (OOP)

spending on cost-sharing and noncovered services for all household survey respondents. However, because the AHSIM model cannot use actual NMES-2 expenditure data directly, data on OOP spending reported in the household survey are used to develop a set of estimates that can be incorporated into the model.⁸ In particular, a system of equations was estimated to predict the percent of expenses paid out-of-pocket in the baseline as a function of demographic characteristics, insurance coverage, health status, and other relevant explanatory variables. These equations were then used to impute baseline OOP spending as a percent of imputed total spending, by type of service. While baseline expenditures are imputed in the AHSIM Model, they are still internally consistent with the rest of the NMES-2 data because the estimation procedures preserve the pattern of spending observed in the original household survey data.

5. Income and Payroll Taxes. The AHSIM model distinguishes between households and tax filing units. The effect of wage changes induced by employer mandates on federal personal income and payroll taxes can be calculated with respect to the 1991 tax treatment of employer paid premiums.

6. Total Health Care Spending for the Nonelderly. The AHSIM baseline includes most health spending by the civilian, resident population of the United States under the age of 65. AHSIM excludes the institutionalized population, Medicare beneficiaries among the nonelderly, and spending by active-duty military personnel.

7. Adjustments to AHSIM Baseline Data. Because the aggregate health insurance premiums reported in the HIPS component of NMES-2 are not consistent with the benefits paid by private health insurance according to either the Household Survey or the National Health Accounts, the NMES-2 HIPS-based premiums are calibrated to these other data sources. Tax estimates and wage income are calibrated to SOI data, as described above. In general, according to extensive analysis by HCFA and AHCPR staff to account for differences in definition and coverage, the NMES-2 expenditure data and the National Health Accounts yield similar estimates.

III. Premium Estimation Under Reform

Two agencies, the Health Care Financing Administration and the Agency for Health Care Policy and Research, estimated the cost of health insurance premiums under reform. Their

⁸Actual NMES-2 expenditure are not used as baseline spending in the AHSIM Model for two reasons. For some people, e.g., those affected by the expansion of Medicaid eligibility, baseline insurance status is different than what it was in 1987 when the NMES data were collected. In addition, it is important that reform expenditures only differ from baseline for reasons related to reform. Because reform expenditures must be predicted for people based on their "new" insurance status, it is helpful to predict baseline spending with the same methodology.

estimates are in 1994 dollars and reflect the benefits included in the standard benefit package. The premium estimation methodology used by each of these agencies is described below.

A. Health Care Financing Administration:

The first step in HCFA's simulation process was to determine each individual's insurance status. The modelers used CPS indicators for this, and considered a person to be insured if he/she was covered by employer-sponsored insurance, other private insurance, CHAMPUS, Medicare, or Medicaid. Insurance could be either in one's own name or through inclusion in a policy held by an adult in the insurance unit. Also, some dependents are covered by private insurance policies owned by people outside the family (for example, a child of divorced parents may be covered through insurance carried by the parent who does not live with the child).

HCFA modelers then adjusted health expenditures to reflect the coverage offered through the regional alliance plan. That coverage is restricted to hospital care, physician and other professional services, prescription drugs, and durable medical equipment other than vision and hearing products. Therefore, the analysts excluded all other National Health Accounts expenditure categories. The cost of coverage for mental health, dental, and preventive care in the standard benefit package was estimated separately, from aggregate data, and added in at the end of the process. Once expenses were adjusted for coverage differences, the modelers applied the fee-for-service plan deductibles, coinsurance, and cost-sharing limits to each person covered through the regional alliance.

An insurance-induced demand adjustment was applied to all those enrolled in the regional alliance. The basis for the induced demand was the difference between out-of-pocket spending under current law and that determined by the reform simulation described above. The induction factor varied by type of service. The application of the factors and the specific values used are described in appendix A. Post-induction spending is equal to the expenditures calculated previously plus (minus) the induced spending calculated as described.

Following these steps, HCFA analysts imputed expenses to currently uninsured people. Existing patterns of use for the uninsured person were discarded, because those patterns are influenced by the absence of insurance. An imputation file was created for each service covered under the regional alliance. To create the file, insured people (excluding people who received SSI cash payments) were divided into groups according to gender, four age classes, and three poverty status classes. Expenditures were tabulated for each group to determine: (a) the proportion that had no expenditure and (b) mean expenditures and use for each decile of the user distribution.

Expenses were imputed for an uninsured person using these imputation files. For each

type of service, the person was assigned a random number ranging from 0 to 1. If that random number fell within the nonuser proportion for the service, the person was given no expenditure for the service. Otherwise, the person was given the mean expenditure and use for the decile of users into which the random number placed them. Analysts assumed that facility and physician use was correlated for hospital services, and used the same random number for hospital inpatient and physician inpatient use. They did the same for hospital outpatient and physician outpatient, and for hospital emergency room and physician emergency room use.

Analysts performed a final simulation to determine which people were covered by the alliances. Typically, they excluded people who received AFDC or SSI cash payments. Similarly, most Medicare enrollees were excluded; only those who worked or whose spouse worked were included in the premium calculations. The remaining people were divided between the corporate alliance and the regional alliance according to the worker status of the adults in the insurance family, and were assigned to one of three policies: individuals (and couples with no dependents), one adult plus dependents, and two adults plus dependents. In a final pass through the family's health expenditures, analysts applied the family limits on out-of-pocket spending to determine the plan benefits and copayments.

In order to generate an upper-bound discount estimate, whenever a two-earner couple had one worker in a large firm (5,000 or more workers) and one in a firm that would be covered through a regional alliance, the couple was assumed to choose coverage in the regional alliance. This maximizes the potential cost of the discounts costs given that no government discounts are available through the corporate alliances.

After plan benefits had been determined, premiums were calculated for each of the policy types and alliance types. An offset was applied to expenses to reflect current-law cost-shifting attributable to uncompensated care. Under the current system, private sector premiums are higher than they would be if there were no uncompensated care in the system since providers pass these unpaid costs on to insured, paying patients. Under reform, all persons will be insured; consequently, baseline premiums should be reduced to reflect the elimination of non-payers from the system. A load factor was applied to the (reduced) benefit cost per policy. The load factor was 15 percent for the regional alliance.

B. Agency for Health Care Policy and Research:

AHCPR's method of generating premium estimates has seven steps. First, following conventions in health economics, AHSIM estimates a two-part model of expenditures for each service. The unit of observation is the person. The first equation in each service's set of two equations estimates the probability of using the service at all as a function of demographic, income, insurance, employment, and health status measures from the 1987 NMES-2. The

second equation estimates annual expenditures on the service for all users of the service, as a function of the same explanatory variables. Combining the result of these equations (i.e., multiplying the probability of use times the coefficients in the second equation) yields an equation that predicts expenditures for each type of person. Predicted expenditures are aged to 1994.

Health expenditures for each person are then predicted for each of the ten services included in the AHSIM Model using this system of equations. Predictions for both the probability and the level (given any use) of an expense were made for each person based on these regressions. The procedure assigns the same expected values to people with private insurance and similar personal characteristics, based on a hypothetical "average" insurance policy. Expected values are modified to take into account specific plan provisions using information from the RAND National Health Insurance Experiment about the effects of such provisions. Reform expenditures are imputed to all people in the model using a stochastic process that maintains observed correlations in expenditures across service types while controlling for the demographic characteristics and health status of individual NMES-2 respondents.

Every individual included in the AHSIM Model actually had three types of reform expenditures assigned to them, indicating their (assumed) behavior under fee-for-service (FFS), managed care (HMO), and preferred provider (PPO) insurance arrangements. Expenses for benefits paid, cost-sharing and noncovered services were calculated separately for each type of plan by applying claims-processing logic to the appropriate estimated expenditure. Premiums for each type of insurance plan were computed on the basis of average benefits paid per insurance policy plus an administrative load set at a percent of benefits paid. In this way, each person was taken into account in computing initial premium levels. Premiums were adjusted for current regional variations in prices.

Individual choice of health plans under reform was modelled by randomly assigning health insurance units to one of the three types of plans (FFS, HMO, PPO) described above. The assumed probabilities of selecting particular plans were based primarily upon market shares observed by HIAA in their annual surveys, trended forward to 1994. These estimates were modified by assuming a 10 percent reduction in FFS under reform as a result of managed competition. Market shares were allowed to vary on the basis of region, urban/rural location, and the availability of discounts for out-of-pocket (OOP) expenses and premiums.

Two passes through the data are made to compute the final set of premiums. The first pass implements decision rules regarding the distribution of premium payments under reform. It also computes the cost of noncovered services and cost-sharing requirements borne by individual households. Based on these calculations, the model determines the extent to which

a household's direct costs will be offset by supplemental insurance and OOP discounts. In the second pass through the data, expenditures are increased to reflect additional spending induced by supplemental insurance and OOP discounts. Insurance premiums are then adjusted to reflect these higher expenditures.

C. Choice of Premium Estimates for Budgeting Purposes:

One set of premium estimates had to be chosen for final budgeting purposes. Although AHCPR's premiums were used by that agency in their estimation of discounts to employers and households and those discount estimates were used as a check on estimates done by HCFA and the Urban Institute, the Administration opted to use the HCFA premiums for purposes of final federal budgeting and distributional effects analyses.

This choice was made for two reasons. First, the premiums estimated by HCFA were higher than those estimated by AHCPR, and it was viewed as desirable to have an official estimate that was more conservative (i.e., that would lead to higher costs associated with the program -- see Table 1 below). Second, the HCFA estimates are benchmarked to the National Health Accounts, the most reliable measure of aggregate spending in the current health care system. Given that the National Health Accounts are considered to be the "gold standard" in measuring total health expenditures, it seemed most appropriate to keep the official premium estimates consistent with that standard.

Table 1
Alliance Premium Estimates

Policy Type:	HCFA	AHCPR
Single	\$1933	\$1735
Couple	\$3865	\$3471
One Adult Family	\$3894	\$3647
Two Adult Family	\$4361	\$4262

IV. Discount Estimates

The national health care reform plan includes a number of different discounts, targeted at different payers. There are two employer discounts: one directed at all firms in the regional alliance, and one directed at small firms with less than 75 employees. There is a discount for the family share (20 percent of the actuarial value) of premiums and for out-of-pocket

payments for both working and nonworking low income families. There is also a discount for the 80 percent premium share for those families who do not have at least one full time worker (or equivalent), including early retirees. The major models are similar in how they estimate most components.

A. Employer Discounts:

The general firm discount consists of a 7.9 percent of payroll cap on all firm premiums, regardless of firm size, provided the employer is in the regional alliance. If the cost of providing 80 percent of the adjusted premium per worker exceeds 7.9 percent of firm payroll, the share paid by the federal government is equal to the difference between the two amounts, or:

$$[N_S(.8P_S) + N_C(.8P_C) + N_{SP}(.8P_{SP}) + N_{DP}(.8P_{DP})] - (.079 * \text{firm payroll})$$

where N is the number of workers of each contract type (S=singles, C=couples without children, SP=single parent families, and DP=dual parent families) and P is the adjusted per worker premium for each contract type.

The small firm discount schedule provides lower payroll caps (less than 7.9 percent) for firms with less than 75 employees and average pay below \$24,000 per year. The small firm schedule is shown in Table 2.

Table 2
Small Firm Discounts

Average Firm Payroll	Size of Firm* (Number of Employees)		
	Less Than 25	25 to 50	50 to 75
Less \$12,000	3.5%	4.4%	5.3%
\$12,000-15,000	4.4%	5.3%	6.2%
\$15,000-18,000	5.3%	6.2%	7.1%
\$18,000-21,000	6.2%	7.1%	7.9%
\$21,000-24,000	7.1%	7.9%	7.9%
Greater Than \$24,000	7.9%	7.9%	7.9%

*Because 75 workers was not a firm size break included in the data sets being used, modelers were asked to use a firm size of 100 for this subsidy calculation. Given that the subsidies will apply only to firms up to size 75, the results overestimate the subsidy costs.

1. **TRIM2: Employer Discounts.** In the TRIM2 model, employer obligations (either 80 percent of the adjusted premium for each worker or a percent of total payroll) are calculated for each worker; there are no firms per se on the CPS, although each worker has employer information associated with them. TRIM2 assigns firm average payroll information from the County Business Patterns (CBP) data to each worker, using a statistical matching procedure that relies on industry (the 3-digit SIC codes), state of residence, and establishment size.

In addition, an average firm premium is imputed to each worker. Take, for example, retail firms with 100-500 workers. Assume that according to the CPS, of the workers who report being employed by that type of firm, 40 percent are singles, 20 percent are married but have no children, 30 percent are married with children, and 10 percent are single parents. The weighted average firm premium that an employer of that type faces is equal to

$$(.4P_S)+(.2P_C)+(.1P_{SP})+ (.3P_{DP})$$

where P_S , P_C , P_{SP} , and P_{DP} are as described earlier.

The employer's payment is proxied by the comparison of average pay times the appropriate percentage cap (3.5 percent to 7.9 percent) to 80 percent of the average firm premium. If the 80 percent of the average firm premium is less than capped average pay, the employer would pay 80 percent of the correct adjusted premium for each worker. If, on the other hand, capped average pay is less than 80 percent of the average firm premium, the employer would contribute 7.9 percent (or the appropriate percentage less than 7.9 percent) of total payroll to the alliance.

If the firm cap is the less expensive option, the worker's record is appended with an employer payment equal to the appropriate cap times average pay in the firm. The amount paid by the federal government on behalf of the employer is also added to the record in the amount of:

$$(.80P_i)-(CAP*(Avg. Firm Pay))$$

where P is the adjusted per worker premium for the worker's health insurance unit type i (single, couple, single parent, dual parent), CAP is equal to the appropriate percentage cap (ranging from 3.5 percent to 7.9 percent) and $Avg. Firm Pay$ is equal to the firm's average payroll as imputed from the CBP data.

If, conversely, 80 percent of the adjusted per worker premium is the less expensive option, the worker's record is appended with an employer payment equal to $.80*P_i$, where i is equal to the appropriate health insurance unit type for that worker, and there is no government employer discount.

2. HCFA: Employer Discounts. In the SPAM model, the basic calculations of employer discounts are similar to those in TRIM2, other than the development of firm-level average payrolls. While TRIM2 imputes payroll data from the County Business Patterns data set, SPAM uses payrolls created by synthesizing firms from employees on the CPS. For each record of an employee on the CPS, one of the firms created using that employee is linked back to serve as the firm description for that employee. The resulting payroll distribution is similar to that implied by the CBP.

3. AHSIM: Employer Discounts. In the AHSIM model, the calculations are also similar to those in TRIM2. AHCPR uses County Business Pattern data for estimating average payroll. The links to NMES-2 make use of the Household Survey detailed responses by firm-size, industry, and other variables, confirmed by the NMES-2 Health Insurance Plan Survey.

B. Discounts for the Self-Employed.

Those individuals who are self-employed are obligated to make a contribution to the alliances based upon the same schedule used to determine small business payments. Those with self-employment income between \$0 and \$12,000 per year, for example, pay the lesser of 3.5 percent of self-employment income and:

$$(.80 * P_i) - EC$$

where P_i is as before and EC is the credit received by the self-employed person due to employer contributions made on their behalf while doing wage work. So, for example, a self-employed person who is also employed by a firm and who is working a full-time, full-year job for wages/salaries has no further obligation with regard to the 80 percent/employer share. An individual who works full time for wages for 8 months and then quits that job and becomes self-employed is only obligated up to a maximum of 4 months of the 80 percent of the adjusted per worker premium for his/her health insurance unit type.

C. Discounts to Low Income Families.

Low income workers and non-workers (those with family income less than 150 percent of poverty¹⁰) are eligible for government discounts to assist in the payment of the family share of the premium and to assist with family out-of-pocket payments (co-insurance and deductibles). The family premium share discounts work as follows:

¹⁰The family size specific poverty guidelines used are as follows:

single -- family size is 1

couple -- family size is 2

single parent family -- family size is 3

dual parent family -- family size is 4.

1. Those with family incomes at or above 150 percent of poverty are responsible for paying the full 20 percent share, subject to a maximum of 3.9 percent of family income.
2. Those with family incomes below 150 percent of poverty have their premium obligation calculated as:

$$MARG_1(INC_1 - 1000) + MARG_2(INC_2 - INC_1)$$

where INC_1 is equal to the family income up to the appropriate poverty guideline, INC_2 is equal to family income if it exceeds 100 percent but is less than 150 percent of the appropriate poverty guideline, $MARG_1$ is the contribution rate applied to family income below poverty, and $MARG_2$ is the contribution rate applied to family income between 100 and 150 percent of poverty.

The two contribution rates are such that families below poverty do not pay more than 3 percent of income for their family premium share contribution, those with income below \$1000¹¹ have no premium contribution. Families at 150 percent of poverty pay the full 20 percent share, or 3.9 percent of family income, whichever is less. The government payment is equal to 20 percent of the actuarial premium for the health insurance unit type, less the family contribution calculated above. For purposes of this calculation, family income is equal to adjusted gross income less unemployment compensation plus non-taxable interest income.

For each marginal rate ($MARG_1$ and $MARG_2$), there are two sets of rates to be used. The first set ($MARG_{1single}$, $MARG_{2single}$) is applicable for single health insurance units and uses the poverty guidelines for a family of size one. The second set ($MARG_{1other}$, $MARG_{2other}$) is applicable to all other health insurance units and is based on the poverty guidelines for a family of size four.

Set one is calculated as follows:

$$MARG_{1single} = (0.03 * POVG_1) / (POVG_1 - 1000)$$

$$MARG_{2single} = ((0.2 * PREM_s) - (0.03 * POVG_1)) / (0.5 * POVG_1)$$

where $POVG_1$ is based on the poverty guidelines for a family of size one, and $PREM_s$ is the premium for a single individual. In 1994, these rates are estimated to be 3.5 percent and 4.8 percent, respectively.

Set two is calculated as follows:

¹¹In 1994 dollars. The income "disregard" is indexed by the CPI in future years.

$$MARG_{1_{other}} = (0.03 * POV_{G_4}) / (POV_{G_4} - 1000)$$

$$MARG_{2_{other}} = ((0.2 * PREM_{DP}) - (0.03 * POV_{G_4})) / (0.5 * POV_{G_4})$$

where POV_{G_4} is the poverty guideline for a family of size four, and $PREM_{F_2}$ is the premium for a dual parent family. In 1994, these rates are estimated to be 3.2 percent and 5.8 percent, respectively.

These rates result in singles and dual parent families paying their full 20 percent premium share at 150 percent of poverty. At 150 percent of poverty, singles pay 3.6% of their income and dual parents families pay 3.9 percent. When the second set of marginal rates are applied to single parents and couples, these families are paying approximately 3.9 percent of their income at 150 percent of their appropriate poverty guideline (family size set at three for single parents and two for couples); however, that amount is less than 20 percent of their respective premiums. Consequently, couples and single parents with incomes in excess of 150 percent of poverty will be required to pay the lesser of 20 percent of their premium and 3.9 percent of income.

An out-of-pocket spending discount is available for those families below 150 percent of poverty who live in an area that does not provide access to a low cost sharing (HMO) plan. In such cases, the family is only obligated to pay the cost sharing that would be required if the family had actually enrolled in an HMO (i.e., \$10 copayment for outpatient services); and discounts will be available for the remainder.

Families without at least one full time worker or equivalent¹² may be required to pay at least some portion of the 80 percent adjusted premium share that is covered for workers through their employers. Families with non-wage income below 250 percent of poverty are eligible for some subsidization of this obligation. If eligible, a family's payment for this portion of the premium is equal to:

$$MARG_3(NWINC_1 - 1000) + MARG_4(NWINC_2 - NWINC_1)$$

where $NWINC_1$ is equal to the family non-wage income up to the appropriate poverty guideline, $NWINC_2$ is equal to family non-wage income if it exceeds 100 percent but is below 250 percent of the appropriate poverty guideline, $MARG_3$ is the contribution rate applied to family non-wage income below poverty, and $MARG_4$ is the contribution rate applied to family non-wage income between 100 and 250 percent of poverty. $MARG_3$ is set such that families below poverty do not pay more than 5.5 percent of their non-wage income

¹²Two examples of families with a "full time worker equivalent" are:

1. each spouse works half time for the full year;
2. one spouse works full time for 8 months and the other works full time for 4 months.

for this portion of the premium, and families with less than \$1000 in non-wage income have no required contribution towards this portion of the premium. The federal payment is equal to 80 percent of the appropriate adjusted per worker premium less employer payment credits, less self-employment contributions, and less family contributions as defined above.

Non-wage income is calculated as Adjusted Gross Income (AGI) less wages and salaries less unemployment compensation and less self-employed income.¹³ Income in this category includes: rents and royalties, interest (including non-taxable interest income), dividends, alimony, capital gains/losses, the taxable portion of social security, partnerships, and trusts. Aside from items mentioned above, other categories of excluded income are: welfare payments, VA benefits, worker's compensation, child support income, inherited money, and proceeds from life insurance.

There are four sets of contribution rates which can be applied to non-wage income: one each for single, couples, single parent, and dual parent families. They are calculated using the formulas shown below, using the family sizes of 1, 2, 3, and 4 respectively to determine poverty guidelines.

For family type 'i':

$$MARG_{3_i} = (0.055 * POVG_i) / (POVG_i - 1000)$$

$$MARG_{4_i} = ((0.8 * P_i) - (0.055 * POVG_i)) / (1.5 * POVG_i)$$

where $POVG_i$ is the poverty guideline for the appropriate family size, and P_i is the appropriate adjusted per worker premium. In 1994, these rates are estimated to be as follows: for singles, 6.4 percent and 10.7 percent; for couples, 6.1 percent and 10.9 percent; for single parent units, 6.0 percent and 9.8 percent; for dual parent units, 5.9 percent and 7.5 percent.

These rates were calculated so that families pay their full employer share of the premium at 250 percent of poverty.

D. Retiree Discounts.

Families with retirees¹⁴ are eligible for a special discount. When fully phased in, government discounts cover the full 80 percent/employer share for non-working retirees.

¹³The actual legislation excludes wages and salaries up to \$60,000 per year. Wages and salaries in excess of this amount count towards this calculation. The \$60,000 exclusion cap was not modelled, making the subsidy estimates somewhat over-stated.

¹⁴The policy defines retirees as those nonworkers who have fulfilled a requirement of a minimum number of working quarters and who are between the ages of 55 and 64, inclusive. However, the models being used to simulate the cost of the plan do not have data on quarters worked. Consequently, all individuals 55 to 64, who are not working or work part time or part year, are modelled as being eligible for the special retiree subsidy.

Government discounts are offset to some extent by the employers of retirees who work part time and the employers of working spouses. For example, a 58 year old man who is working half time will have half of his employer contributions made by his employer and half of his contributions will be made by the federal government. No government discount is necessary when a retiree has a full time working spouse, as the spouse's employer's contributions will fulfill the coverage responsibility. However, if a retiree is married to a non-worker, the government contribution will cover the couple (or family).

E. Choice of Discount Estimates for Budgeting Purposes and Distributional Analyses:

For reasons noted above in the section on premium estimation, the HCFA premiums were selected as the official Administration estimates. This choice necessitated that a model using the HCFA premiums be used as the official Administration discount estimates. For this reason, the discount estimates used for budgeting purposes are from the HCFA simulation model. It should be noted however, that all three discount estimates were within 7 percent of each other. Consequently, all estimates are well within the discount "cushion."¹⁵

For purposes of distributional analyses, the Administration's official estimates come from the Urban Institute's TRIM2 model, which was benchmarked to the National Health Accounts and which used the HCFA estimated premiums. The Urban Institute is the most experienced of the three groups in doing the type of complex distributional analyses needed for the reform process.

V. National Spending Impacts

The change in spending produced by health reform can be summarized in terms of the impacts on businesses, households, and governments. Present business spending is here limited to employer contributions for employer-sponsored health insurance and for active workers and retirees. Under reform, employers are required to pay 80 percent of the average worker premium in their area (net of discounts) for most workers. Beyond the required outlays, it is expected that there will be supplementation of the required coverage. Those employers currently paying more than the required employer contribution percentage, or buying richer coverage (e.g., lower cost-sharing) are assumed to continue to pay more than the required minimum.

The calculations of changes in business outlays are similar in TRIM2 and SPAM. If an

¹⁵The HCFA discount estimates were increased by 15 percent in an effort to budget a more conservative level of discounts.

employer currently pays more than 80 percent of premiums, TRIM2 increases employer spending under reform to match the proportion contributed by the employer currently, as long as this does not exceed current spending. If maintenance of the current proportion would exceed current spending, it is assumed that employers increase their spending only to the point of current spending. Worker contributions are reduced accordingly. This first part of supplementation is then increased to add the cost for enhancing the richness of coverage up to the current level of plan richness associated with each currently insured worker. The cost of matching the current richness of benefits is paid by the employer and the worker in proportion to current premium contributions.

In the SPAM model, additional coverage is assumed wherever current payments are better for the family than modeled future payments under the mandated benefit package. Supplementation amounts are accumulated equal to the difference between current and required benefits. Employer contributions are assumed to cover the supplement, although employer payments for the required coverage are held to the mandated minimum.

The AHSIM Model assumes that both employers and households attempt to hold their spending on health insurance constant from baseline to reform. To the extent that baseline spending on employer-sponsored insurance exceeds expenditures required under reform, employers are first assumed to buy down their employees' required contributions. If baseline spending exceeds reform requirements for either households or employers after taking this transfer into account, the AHSIM model then allows both households and employers to buy supplemental insurance. For each health insurance unit in AHSIM, the actuarial value of supplemental insurance purchased under reform cannot exceed baseline levels. The total amount of supplemental insurance is also limited by the level of potential out-of-pocket expenses (cost-sharing plus noncovered services) under reform. Supplemental insurance is also assumed to carry a higher administrative load than basic health plans, 25 percent in most recent simulations. Any employer excess that remains after buying supplemental insurance is assumed to increase other tax-preferred fringe benefits.

Household spending is defined to be the employee contributions for employer-sponsored health insurance, direct premiums for non-group coverage (under the current system) or direct purchase of alliance coverage (under reform), and cost-sharing payments. In the baseline, the employee contributions are defined to include employee payments irrespective of tax status; pre-tax employee contributions are counted as employee payments despite IRS treatment of such sums as employer contributions. To the extent supplementation implies higher business payments, household spending is reduced by like amounts. Total changes in cost-sharing are calculated as the net of reduced payments due to new and enriched coverage, against increased cost-sharing attributable to required purchase of insurance leading to increased utilization and some personal payments (rather than reliance on uncompensated care mechanisms).

Government spending changes reflect transfers between the Federal government and other levels of government, as well as increased Federal responsibilities (particularly in arranging discounts for low-wage firms). Baseline Federal spending is primarily Medicaid and Medicare. Under reform, Medicaid non-cash populations move into alliance plans, with some direct business payments. Similarly, more Medicare recipients fall under working aged rules, with direct employer contributions reducing Medicare responsibilities.

State and local baseline spending is primarily Medicaid, although significant sums are currently spent on other programs, most notably direct payments to hospitals. Under reform, Medicaid savings will be redirected under maintenance of effort requirements for use in paying for discounts for low-income populations in the alliances.

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APPENDIX A

**Example of the Application of an Induction Factor
To a Change in Insurance Status**

	Before Change	After Change
Current law spending	\$200	\$200
Multiplied by copayment rate	<u>x 50%</u>	<u>x 20%</u>
Out-of-pocket spending	\$100	\$40
Initial change in out-of-pocket		\$60
Multiplied by induction factor		<u>x 0.7</u>
Equals change in total spending		\$42
Current law spending		\$200
Plus induced demand		<u>42</u>
Equals new total spending		242
Less new out-of-pocket (20%)		<u>- 48</u>
Equals new benefits		194

Induction Factors Used in SPAM Simulations

Hospital inpatient (facility and physician)	0.3
Prescription drugs	1.0
Emergency room services and DME	0.0
All other services	0.7

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